Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		1. Decedent's Nen	ne (First, Middle, Las	t)				te of		2. Dete of D	Reg. No.		3. Time of	Deeth
	Physician	THE RESERVE OF THE PARTY OF THE	n Domini		a++					Month	Day	Yeer	2:30	
1	/Medical		(If not institution, give						4b. City, Town, or	Apri		2000		P
	Examiner		. Andrev		"/				Severn				rundel	1
	Funeral Director	5. Sociel Security I 103–16–4	783	_	Age (In yrs. 78	lest birthdey) Yrs.	If Unde Months	r 1 Year Deys	If Under 24 Hrs Hours Min	8. Dete of Bi (Month, D Jan 2	rth ay, Year) 7, 1922		place (State o intry) nnsylva	
pue	1	Usual Residence of	of Decedent 10b. County	Target .	10c. Cit	y. Town or Lo	cation						10d. Inside Ci	
не Магую	Sert sho	MD	Anne Aru	ndel		verna 1	Park						1 🗆 Yes	2€ No
eth with ti	or items 23a or 28a-f show miner must be notified at Funeral Director	10e. Street and Nu 123 St.	Andrews				21	146			10g. Citizen of	SA		40
5-UUZU 72 hours after deeth with the Maryland	5 6		ried 2 🖾 Merried 4 🗆 Divorced	12. Wes Deceder Armed Force 1 Yes 2 If Yes, Give Yeer or Date:	s? ^{] No} 194.	3. 13. 1	Wes Dece If Yes, spe 1 Yes		dispanic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	Speci	ck, White	ican Indien, , etc. nite	
2	ygiene. Net then "netural; It, the Wedical Exa	(Spe	15. Decedent's Ed city only highest grad ondary (0-12)		r 5+)				petion during most of wa d)		16b. Kind of E		ndustry	J.
C Z I Z I	ther then out, the Comp			2		Cons	truct	ion	Executiv		Buildin			
2 8	a very		(First, Middle, Last) c Barrett				-			me (First, Middle Ann Tig		me)		
	7 is me traum		leme/Relationship (7 . Barrett						and Number or R Ws Road,				p Code) 21146	
Baltimore,	artment of Heel ortant: if Item 2 Injury or other 8.		position Cremetion 3 5 Other (Specify		e Oui	lace of Disponenter, cremeter, creme	natory or	her pla	¹ elds	Apr 25 2000	20c. Location			
Baltimo	Department of important: if any injury or phice.	21. Signature of 5	Service Licen:	3714		B	2. Neme e arrar	nd Addre	ss of Fecility Sons, E Ritchie F	A. Sev				
//	ysician Medical taminer	Immediate Cause disease or conditi resulting in death)	on	a,		Cov or as e consec	dio.	~ , U	pally			1	Onset end I	Death
58/50, tificate be assecuted	g physician end as the bunal-transit	Sequentially list or if eny, leading to in cause. Enter Unit Cause (Disease or thet initiated event	onditions, mmediate enving r injury	b		r es e consec			P.	- V. T.		1		
BOX 06/	attending physicie for usa as the bu	resulting in death)	Last	d	Due to (or	r es e conseq	juence of)							
daat	ed for	Pert II. Other signi	ficant conditions co	ntributing to death	but not resu	ulting In the u	nderlying	cause gi	en in Pert I.	23b. Dio	tobacco use c	ontribute	to the cause o	of death:
that the	hed by the attending detached for usa			3 - 5						1	Yes 2 70	3 □ Pro	obably 4	Unknow
VITAL MECONDS, P.O. BOX	sate has been signe page 2 should be of Completed by							30			s an eutopsy omed?	9	Vere autopsy f veilable prior t ompletion of c f deeth?	to
E P	page 2	200								10	Yes 2010	1	□Yes 2□	No
	s certificate director, pag	25. Wes case refe	rred to medical						26. Plece of De	ath (Check only	one)			
Of VITA	0 0	examiner?	No	Hospitel: 1 Inpe	tient 2 🗆	ER/Outpetier	nt 3 D	OA Oti	ner: 4 Nursing	Home SERes	idence 6 🗆 Ot	her (Spec	ify)	
Attending Ph	ath. : After the funeral	27. Manner of Dea 1) Atturel 2 Accident	th 5 Pending investigation	28a. Dete of Ir (Month, L	ijury Dey Year)	28b. Time of Injury	f M	28c. Inju Wo 1 □	ry et rk? Yes 2 □ No	28d. Describe	how injury occu	rred	- 17	1
5 6	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Place of	njury - At ho etc. <i>(Specif</i>)	ome, ferm, str	reet, fecto	y, office			(Street and Num own, Stete)	ber or Ru	rel Route Num	nber,
• Hospital	in 24 hours he Funeral pletaly filled edical C	29a. Certifier (Check only one)	Certifying Phy Medical Exam	rsician: To the bes Iner: On the basis and manner	of examinet	wiedge, death tion end/or in	n occurred vestigation	at the ti	me, date end plec opinion, death occ	e, end due to the urred at the time	ceuse(s) and m , date and place	anner as , and due	stated. to the ceuse(s	6)
To the	To the comple	29b. Signeture end	f title of certifier				29	c. Licens	se number		29d. Date sign	ed (Month	, Dey, Year)	
	> - 0	> Sh	John C.	me.	Com			9	7203 (٥	4/24	1201	0	
		30. Neme and edd	ress of person who c	ompleted cause of	deeth (Item	123a) (Type,	who seems	Dr	in a	her fer,	M1) 2,	1619	9	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

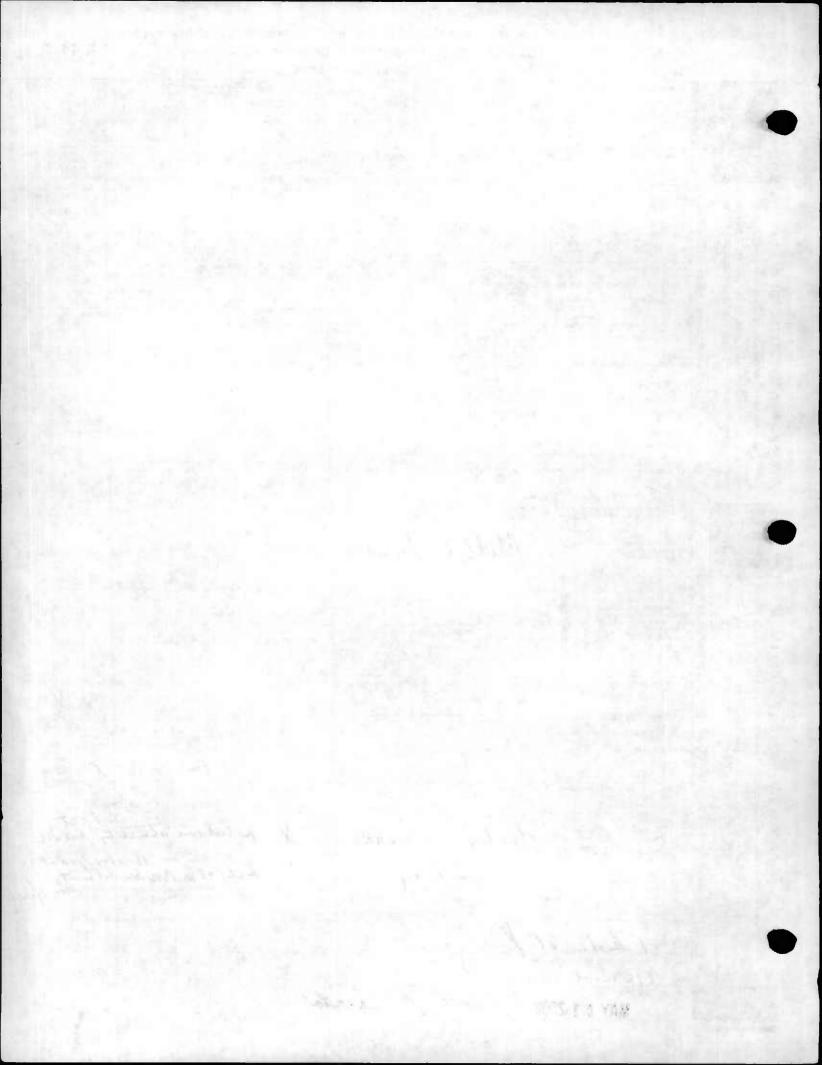
ian	1. Decedent's Name (First, Middl	le, Last)	Ce	ertificate of	Death	2. Date of Dea	Reg. No.	3. Time	ot Death
	DAYTON	٧.	BAI	RTELL		APRIL	17 200	Year 11	o Pim
cal ner	4a Facility Name (If not institution	n, give street and number)			4b. City, Town, or L	11 11			
	North Arundel Ho	105 latias	a lotion	rive	Glendur	SIN	Anne	Arunda	L
	5. Social Security Number	1 DM SELE	yrs. last birthday	Months Days		8. Date of Birt (Month, Day	h v. Year)	9. Birthplace (State Country)	or Foreign
	579-34-4889	ILIM ACIE	71 Yrs.			NOV. 2		NORTH CAP	OLINA
	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside	City Limits
ō					- 17				2 ⊠ No
Director	10e. Street and Number	NNE ARUNDEL	G	LEN BURN:	TE	T	10g. Citizen of Wi	hal Country?	
	109 MARTHA ROA	n			21060		U.S.		
Funeral	11. Marital Status	12. Was Decedent Ever	in U,S. 13		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		- American Indian,	
by Fur	1 ☐ Never Married 2 Married	If Yes, Give		It Yes, specify Cul		Rican, etc.)	Black,	, White, etc. WHITE	
	3 ☑ Widowed 4 ☐ Divorced		46- 0	donte Herral Occur			40h Kindat Dua	7	
Completed	(Specify only highe:	1	(Giv	edent's Usual Occu e kind of work done DO NOT use retin	e during most of work	ing	16b. Kind of Bus	aness/industry	
E C	Elementary/Secondary (0-12)	College (1-4or 5+)			/		CMAMP AT	MB 1937 7 3 3 2	
	17. Father's Name (First, Middle,		DUPE	RVISOR	18. Mother's Nam			<u>'_MARYLANI</u> }	
o Be	ARTHUR	Α.	VANDERB	URG	DAYTON		тил	CKSON	
H	19a. Informant's Name/Relations				et and Number or Rur	al Route Numbe			
	CHERYL B. YOUNG	GMAN (DAUGHTER			SA ROAD, M				
	20a. Method of Disposition	21	0b. Place of Disp	osition (Name of ematory or other pla	2001	Date	20c. Location - C	ity or Town, State	
	1 Burial 2 Cremation 4 Donation 5 Other (S				TION CENT	-19-00		ATT.TE ME	
	21. Signature of Experist Slavce		CHESAF E	22. Name and Addr	ress of Facility SIN	GLETON	FUNERAL.	HOME P 2	
	11/11/14	apan Mao 2	1 1 -		AVENUE, S.				
	23a. Part1. Enter the disease/or shock, or heart tailure. List	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NAMED I		nter the mode of dy	ring, such as cardiac	or respiratory ar	rest.	Approxime	le
	shock, or heart tailure. List	onlylone cause on each line.						Onset end	tween Daalh
	Immediate Cause (Final disease or condition	Asp	IRATI	(10					
	resulting in death)	a	to (or as a conse					1	
ner		CoRo		AD	Nu (DISKAKE			
Examiner	0	b	to (or as a conse	110	1				
M	Sequentially list conditions,			quence of):			-		
	sequentially list conditions, if any, leading to immediate cause. Enter Underlying	END STA	YUF	equence of):	FAILL	WE			
dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ENO STA	TUE to (or as a conse	RENAL	FAILL	une Une			
dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o ENO 214	to (or as e conse	RENAL	FAILL	INE			
dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ENO 2124	TUE to (or as e conse	RENAL	FAILL	INE			
dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d		REN AC quence of):				ribute to the cause	of death?
dical	Part II. Other significant condition	d.	t resulting In the	REN AC quence of):	iven in Part I.		obacco use cont	ribute to the causs	
by Physician/Medical	Part II. Other significant condition	d	t resulting In the	REN AC quence of):	iven in Part I.	23b. Did 9	obacco use control	3 ☐ Probably 4] Unknown
by Physician/Medical	Part II. Other significant condition	d.	t resulting In the	REN AC quence of):	iven in Part I.	23b. Did s	obacco use cont	3 Probably 4 24b. Were eutopsy evaileble prior	Unknown tindings
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Kenneth E. Boston III

State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificat	e of	Death			Reg. No.			0 0 0	
	1. Decedent's	Name (First, Midd	dle, Last)						Fair		2. Date of De	ath		Vans	3. Time of	f Death
Physician /Medical	KI	ENNETH :	E. F	BOSTO	N III						Apri	L 25	20	Year	10:47	P.M.
Examiner	- Table 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	me (If not institution							4b. City, To	wn, or L	ocation of Daat	h 4c.	County o	f Death	1	
	Dec 25	Anne Aru	unde]	l Medi	cal Ce	nter			Anna	apol:	is	2	Anne	Arui	ndel	
Funeral	5. Social Secu	rity Number	6. Sex		7. Age (In yr	s. last birthday) If Under		If Under Hours		8. Date of Bir (Month, De DEC.	th Year)		9. Birthp	lace (State o	or Foreign
Director		2-9257	X	KM 2□F	1	7 Yrs.	Widnights	Duys	110013		DEC.	YT 1	982	MAF	YLAN	D
	Usuai Resider	10b. Count			100 /	City, Town or L	ocation							1	0d. Inside C	libra I implian
at Mark		Too. County	7		100.	ony, rown or E	Coation] '		2 No
s or 28s-f show be notified at Director	MARYI.	AND ANN	E_A	RUNDE	L G	AMBRII	LS 101. Zie	Code				10g. Citiz	ran of IAT	h-t Cour		
0 M		FALL RI	DGE	WAY				105	4				USA	nat Court	llyr	
iner must	11. Marital Sta	tue	1	2 Was Dec	edent Ever in	US 13	Was Dece	dent of H	lispanic Ori	igin? (Sr	ecify Yes or No)- ·	4. Race	- Americ	an Indian,	
Fun Fun	1 X Never	Married 2 Ma		Armed F			tf Yes, spe	cify Cube	en, Mexicer	n, Puerto	Rican, etc.)		Biack	, White,	etc.	
Eren by F	3 ☐ Widow	red 4 Divorce		If Yes, G Year or I	ive		1 Yes	2 XNo	Specify:				Specify:	BLA	ICK	
t. the Medical		15. Decede	nt's Educ	ation		16a. Dece	dent's Usu	al Occup	ation			16b. Kir	nd of Bus	iness/Ind	lustry	
o de	Elementary	Specify only higher Secondary (0-12)			(1-4or 5+)	life.	DO NOT u	se retired	during mos	t or won	ang					
or H	1	2th			0		STU	DEN'	\mathbf{T}				NON	E		
Be Sent		ame (First, Middle	, Last)						18. Mothe	er's Nam	e (First, Middle	, Maiden	Su <i>ma</i> me)		
To T	K	ENNETH	BOS	TON J	R.					K	AREN B	ELT				
and and		t's Name/Relation					-				ral Route Numb	-				
n 27	KAREN	BOSTON	(M	OTHER					DGE 1	WAY	GAMBR	ILLS	, M.	D. 2	21054	
9 1 1	20a. Method o	Disposition	2 🗆 🗆	amouat from		. Ptace of Disp cemetery, cre	osition (National or of the control	me of other plac	ca)		Date	20c. Lo	cation - C	City or To	wn, State	
ant: I		ion 5 Other (5		Binovaciroin	A	NNAPOI	JIS M	EM.	GAR	DEN:	5 5/1/	00 A	NNA	POL:	IS, M	D.
A Party S	21. Signatura	of Funaral Sarvice	e License	e MC	0483	? 2	2. Name ar									7
on a grant	R1	Д.	Don			V	VM. R	EES	E &	SON	S MORT	UARY				
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nysician	snock, o	r hearffailure. Lis	st only on	e cause on	each line.										Onset and	
Medical	Immediate Ca	use (Final		M	le.	, /	1	,								
aminer	disease or cor resulting in de	ndition eath)	a	101	ulfil	· IM	we									
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ed by the attendir detached for use / Physician/N	Part II. Other s	Ignificant conditi	lons cont	tributing to c	leath but not re	esulting in the	underlying o	euse giv	en in Part	I.	23b. Did	tobacco	uas con	tribute to	the causs	of death
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d be del															A	
ois of pa												an autop	sy	24b. W	ere autopsy ailable prior	findings
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page 2 should											fr	- o	□No		~	1 No
certificate ractor, pa	25 Was assa	referred to medica	ol I								WZ (S)		JINO	'/	Yes 2□] NO
	examiner?		-	ospital:	Inpatiant 3	M -000		Oth	ar:		th (Check only			. 101		
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is after death. I Director: After to do in by the funeral Certification:	2 Z Accide	e 6 ☐ Could	not be	28e Plac	e of Injury - At	home, farm, s			1		28f. Location	Street an	d Numbe	er or Rura	I Route Nug	pber.
Direction Direct	4 Homic	cide determ	mined	buito	ling, etc. (Spe	city	irott ractor	y, 011100			City or To	wn, State	16	25/04	food	1
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	29a, Certifier	1□ Certifvi	na Phys	ician: To the		duray	th occurred	at the tir	me date ar	nd ptace	and due to the	Causals)	and man	Mar as e	Charles de	-
Pletely file	(Check on			er: On the b							red at the time.					26/00
	one)			3.10 11101			200	c. Licens	e number			29d. Dat		/Month	Day Veed	
Me Me	one)	and title of certific	er	1.			29						e signed	(IMICHIELL)	Day, rear,	
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU AACO HEALTH Certificate of Death AMEND: #16a mcg 4/24/00 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death APRIL **Physician** Year 7.50 AM 23 2000 Betty Louise Croll /Medical 4b. City, Town or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deet Examiner ARUNDEL DLEN BURNIE HRUNDEL HOSTITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb 5 1918 5. Social Security Numb 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F Yrs. Director 82 PA. 202-01-6178 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Director Severna Park Anne Arundel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 'natural', or items 23a 43 West McKinsey Rd. Apt. 203 21146 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Bace - American Indian 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Haalth and Mental Hygiene. em 27 is marked other than Elementery/Secondery (0-12) College (1-4or 5+) Bookkeeper 12 Bookeeper Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Falher's Name (First, Middle, Last) Weaver George Frantz Annie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ormit. Pages 1 and.
Department of Hamilto a
Important if them 27 is any Injury or other
Date. William Croll III 391 Harwin Drive Severna Park, MD 21146 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4/24/00 Catonsville, MD 21. Signature of Familia Service tricensee 22. Name and Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home _M00721 495 Ritchie Hwy Severna Park MD 21146 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or hear feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) Multiple ORGAN FAILURE /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner RENAL FAILURE

Due to (or as e consequence of): physician and the bunal-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760, KIHADDOMYOLYSIS thet initieted events resulting in death) Lest Due to (or as e consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MYOCAKOIAL INPANCION Records, ģ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Vital Hospital or Attending Physicien:
 24 hours after death.
 Funerel Director: After this certificalletely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 UNo 1'Sanpatient 2 ER/Outpatient 3 DOA Division of 27. Menner of Deeth 28b. Time of Injury 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated. Medical 29e. Certifier

30. Name and address hi person who completed cause of death (Item 23a) (Type, Print) State

SAJID 31. Dale filed (Month, Dey, Year)

29b. Signature and little of certifier

32. Registrar's Signature

10002TH

W(1)

APR 2 4 2000

SHARIF

29c. License number

D51245

29d. Dete signed (Month, Day, Year)

301 Hospital Drive' Glen Burnie, MD

ARVNOEL HUSPIPAL - 1410

Abvil 23,2000

21061

Registrar

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State of Maryland / Department of Health and Mental Hygiene

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/Medical		Caroline		Casey			- Ch. T	April			410 am
Examiner	4a Facility Name (if			n <i>ber)</i>		1	lb. City, Town, or Lo			of Death	
.mayat	Univers 5. Social Security Nu		Sex	7. Aga (In yrs. las	st birthday)	If Under 1 Year	Baltimore If Under 24 Hrs.		N/A	9. Birthola	ce (State or Foreign
ineral rector	213-02-146		1□M 270F	55	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da October	2, 1944	Maryla Maryla	y) .
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Funeral	11. Marital Status		12. Was Dece	edent Ever in U,S.	13. W	es Decedent of H	ispanic Origin? (Sp	ecify Yes or No	- 14. Rad	e - Americer	n Indian,
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Be Co	17. Father's Name (F	First, Middle, Las	st)		110116		18. Mother's Name	e (First, Middle,			
To B	Fr	ranklin Ca	asey				Grace (Quade			
	19a. Informant's Nar	me/Reletionship	(Type, Print)		19b. Mailing	Address (Street	and Number or Run	al Route Numbe	er, City or Town,	State, Zip C	Code)
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	20a. Method of Dispo		☐Removal from		ce of Dispos netery, cremi	ition (Name of atory or other plac	(e)	Date	20c. Location -	City or Tow	n, State
	4 Donation			Hillo	crest M	emorial Ce	-		Annapolis		
	21. Signature of Fun	Service Lic	ensee	00	22.	Name and Addre	ss of Facility Jol	hn M. Tay	lor Funer	al Home	e, Inc.
•	-	Ovan	dove				Gloucester		- ,	Maryla	and 21401
	23a. Part1. Enter the shock, or heart	e disease, or co t feilure. List on	mplications that c ly one cause on e	eused the death. ech line.	Do not enter	the mode of dyin	g, such as cerdiac	or respiratory a	rrest,	1 1	Approximete nterval Between Onset and Death
ian ical	Immediate Ceuse (F	inal	CART	TAC ADDV	T MILITY	חווב יויי	MYOCARDIA	T PTDD	CTC	1	Sriset and Death
er .	disease or condition resulting in death)	1	a				MICCARDIA	T LIBRO	515	1	NO 611
ē	Valuation 1			Due to (or a	s a consequ	ence of):				1	
Examiner	Sequentially list con-	ditions	b	Due to (or a	s a consecu	ence of):		_		-	
EX	Sequantially list con- if any, leading to imm ceuse. Enter Under	mediate lying		(3)							
dical	Cause (Disease or in that initiated events resulting in death) La	njury	C	Due to (or a	s a consequ	ence of):					E I I L
			l d								
Slan			0.								
Physician/M	Part il. Other signific										the cause of death?
Y Pt	STATUS	POST LA	PAROTOMY	FOR OVA	RIAN (CARCINOM	A	10	Yes 2 No	3 Probe	ably 4 Unknow
ed by								24a. Was	an autopsy	24b. Wer	e autopsy findings
Completed	- CU			Maria d				perfo	rmed?	com of de	lable prior to pletion of ceuse eath?
mo	0.00							16	es 2□No		Yas 2□ No
BeC	25. Was cese referre	ed to medice!					26. Place of Deat				
TOE	exeminer?	No	Hospital:	npatient 2 EF	VOutpatient	3□ DOA Oth	or:		dence 6 🗆 Oth	ner (Specify)	
Certification: To	27. Manner of Death	5 Pending	28a. Dete	of Injury th, Day Year)	8b. Time of Injury	28c. injur Wor		28d. Describe	how injury occur	red	
cati	2 ☐ Accident 3 ☐ Suicide	investigati	on			M 1	Yes 2□No				
F	4 ☐ Homicide	determine	A Zoe. Place	of Injury - At hom- ng, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (: City or To	Street and Numi vn, Stete)	per or Rural	Houte Number,
	29a Cartifiar	1 Cardibiles 5	thursiology To the	hast of my loan to	ndan de att	nonurred at the city	no date and star	and due to the	aguagia) s = d	00007.0	tod
Medicai	29a. Certifier (Check only one)	Medical Exa	miner: On the ba	best of my knowle asis of examination her steted.	n end/or inve	estigation, in my o	ne, date and place, pinlon, death occurr	ed at the time,	date end plece,	enner as sta and due to t	the cause(s)
4	29b. Signyours and ti	itle of certifier	A	0		29c. Licens	a number		29d. Date signe	ed (Month, D	lay, Year)
-	A MA		111. 0	V 0		0.C.	M.E.		April :	22. 20	000
-	P \	I.To	11 Mar	WIX				1		12, 20	0.0
	30. Name and address	ss of person who	completed ceus	a of death (Item 2	3a) (Type, P				TPLL.	22, 20	
completely filled in by Medical Certifi	30. Name and address		~ 11 - A			rint)	t, Baltim	ore. Ma			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	APIENO#	7	9B 4/26/00 CMH		Cei	tificate of	Death	R	leg. No.		2 Time of Death
	Physicia /Medic	_	Decedent's Nama (First, Middle, Li JAMES DC	BSON				2. Date of Deal Month APRIL	24 200		3. Time of Death 7:45 am
)	Examin	er	4a Facility Nama (If not institution, gi				4b. City, Town, or Lo		4c. County		
			CHESAPEAKE HOS				INTHICUN		ANNE		NDEL
	Funeral Director			Sex 7. Age (In yrs	: last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day) AUG • 7	Year) 1939	9. Birthe Cour MAR	plece (Steta or Foraign ntry) YLAND
	yland		10a. Steta 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Insida City Limits
	death with the Maryland ma 23a or 28a-f ahow mast be notified at		MARYLAND ANNE A	RUNDEL CHU	JRCHTO						1X Yas 2 No
	F V F	吉	10e. Street and Number			10f. Zip Code		1	I0g. Citizen of V	Vhat Cour	ntry?
	ath v	ara .	5452 DEALE CHU		10 1401	20733	Manual Calaba (Ca		USA	- America	an Indian
020	urs after	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed XXDivorced	12. Was Decedent Ever in It Armed Forces? 1 Yes 2 No If Yes, Giva Year or Dates:		Yas Decedent of F f Yas, specify Cub. I ☐ Yes 2\(\frac{1}{2}\)Jo	dispanic Origin? (Spean, Mexican, Puarto Specify:	Rican, atc.)	Blac	k, Whita,	
5-0	netural,	Pete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Giva	lent's Usual Occup	during most of worki	ing	16b. Kind of Bu	sinass/Inc	dustry
21215-0020	C	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life. I	00 NOT use retire USTODIA	d)		JS NAVA	AL A	CADEMY
	Hygie other	Be C	17. Fathar's Nama (First, Middla, Last				18. Mothar's Name				
ylar	2 should be filed and Mental Hygid is marked other sumstic event, the	10	JAMES E. DO	BSON			MARY	WATKI	INS		
, Maryland	1 and 2 sho Heelth and Am 27 is mu ther traum		19a. fnformant's Name/Relationship (GLADYS PEEVY (F	Type, Print) 'RIEND)	19b. Mailin 5452	ng Addrass (Street DEALE C	and Number or Run CHURCHTON	N RD. C	r, City or Town, CHURCH'	Stete, Zip	Code) 20733 MD. 210
Itimore,	sages ant of rt: If h		20a. Method of Disposition *CX*Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		cematary, cren	sition (Name of natory or other ple	GARDENS		20c. Location -		
Balti	permit. P Departmo importan any injur		21. Signefure of Funeral Service Lice		22 V	Name and Addre	SE & SON	S MORT	UARY,	P.A.	
		+	23a. Part1. Entar the disease, or comshock, or heart failura. List only	plications that caused the dea							Approximata Interval Batween
(68760,		Medical Examiner	fmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence or as a consequence	unico at):	Lynn	pho	re gi		
Box	ath certif attending for usa a	Physician/M	- Wantie	d						1	
	y the a	ysk	Part If. Other significant conditions of	contributing to death but not re-	sulting in the ur	nderlying causa giv	ven in Part I.				the cause of death?
J.	s that med b e deta	by Pt						104	es 2ENo	3 □ Pro	bably 4 ☐ Unknowr
Vital Records, P.O	The law requires that the death certials has been signed by the attending page 2 should be detached for usa	Completed						24a. Wes a perform	an autopsy med?	av	ara eutopsy findings ailable prior to impletion of causa daath?
ž	The lay ta has sege 2	E						1 U Y	es 2ENo	10	☐Yas 2☐ No
Ita	delan: The		25. Wes casa referred to medical axaminar?				26. Place of Deatl	h (Check only on	na)		
>	Physic this ce	9	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Ott	ner: 4 Nursing Ho	me 5 ☐ Reside	ence 6 Oth	ar (Specif	vi Hospice
Division of	Attending Physician: or deeth. ector: After this certific by the funeral director,		27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation		28b. Tima of Injury	M 1	ry at rk? Yes 2 □ No	28d. Describe he	ow injury occur	ber	
	al or Attens s after deet it Director: ed in by the	Certification:	3 Suicide 6 Could not be determined		noma, farm, str ify)	eet, factory, office		28f. Location (Si City or Town		er or Run	el Routa Number,
	To the Hospital or Attending Physician: The i within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege	edicai	29a. Certifier (Check only one)	ysician: To the best of my known on the basis of axaminend manner steted.	owledge, death ation and/or inv	occurred at the til rastigation, in my o	me, date and place, opinion, deeth occurr	and due to the cred et the tima, d	ause(s) end me late end plece,	nner es s and due to	tated. the ceuse(s)
	Withi To th		29b. Signatura and fitta of certifier	/		29c. Licens		l l	29d. Data signe		
			· Centri D	ann M	1	1)5	3306		41	1251	100
			30. Nema and address of person who	completed cause of death (Ite	- A	1	Aug	Anna	nlin	mr	100
_			31. Data filed (Month, Day, Year)	1	N	138/1	1100	11111010	01/2	11/1	0140

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MARY FRAZIER LOU APML 25, 2000 09: 22 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner GENERAL HOSPITAL HARFOND FALLSTON FALLSION If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1□M 250 F Yrs. 523-36-7934 Director July 26, 1932 Colorado Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8316 Cypress Mill Rd. 21236 Funeral Hems ! 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 6 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Retail Grocery Store Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Heelth, and Mentel Hy Important: If Item 27 is marked ofth any Injury or other traumatic event Obtes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ella (u/k) Slayman Orne Tappana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. DeUnger / Daughter 8316 Cypress Mill Rd., Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial /2 Cremation 3 DRamoval from S 4 Donation 5 Cithing Pauls Lutheran Cem. 4-27-00 Aberdeen, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Se 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the distance shock, or heart failure Approximate Interval Between Onset and Death all caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting In death) ASCUD /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Diaboto Mulhtus 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy certificate has 1 Yes 210 No 1 ☐ Yes 2 No of Vital Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DEFR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To s after death. I Director: After this d in by the funeral d After this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

X

State Registrar

31. Date filed (Month, Day, Year) APR 27 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

728

29b. Signature and title of cartifier

PRABHU M.D

32. Registrar's Signature

DME

BELATIL MD 21014 410879 6564 BELATIN

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APML 25, 2000

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

1 ☐ Yas 2 No

SALES CLERK

20b. Ptace of Disposition (Nama of

camatary, cramatory or other placa)

Harry J. Lees MU0482 WM. REESE & SONS MORTUARY, P.A.

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)

22. Name and Address of Facility

15509 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Vaar HERBIN 20 2000 11:45AM 4a Facility Nama (If not Institution, give street and number) SOUTH RIVER 4b. City, Town, or Location of Death 4c. County of Death EDGEWATER ANNE ARUNDEL MILLENIUM HEALTH & REHAB. CENTER If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 8. Data of Birth (Month, Day, JULY 27 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Months 1 M 210 F GEORGIA JULY 1918 81 10d. Insida City Limits 10c. City. Town or Location 1 X Yas 2 □ No MARYLAND ANNE ARUNDEL EDGEWATER 10g. Citizen of What Country? 10f. Zip Code 140 TYDINGS DRIVE 21037 USA

Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.)

14. Race - Amarican Indian,

BLACK

21101 Approximata Interval Batwaen Onsat and Death

29d. Data signad (Month, Day, Year)

2501/121

Black White atc.

Specify:

18. Mothar's Nama (First, Middla, Maidan Sumama)

MATTIE TUFF

1000 MADISON ST. APT. A2 ANNAPOLIS, MD.

ANNAPOLIS MEM. GARDENS 4/25/00 ANNAPOLIS, MD.

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code 21403

Data

16b. Kind of Businass/Industry

SNYDERS BOOTERY

20c. Location - City or Town, State

Funeral Director

Physician

/Medical

Examiner

MARY

10b. County

15. Decedent's Education (Specify only highest grada completed)

BENJAMIN POUNDS

Burial 2 Cremation 3 Ramoval from State

19a. Informant's Name/Ratationship (Type, Print) TROY HERBIN (HUSBAND)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licenses

12. Was Decedent Evar in U,S. Armed Forces?

1 Yas 2 No If Yas, Giva Yaar or Datas:

Cotlega (1-4or 5+)

5. Social Security Number

212-18-4316

10e. Street and Number

11 Marital Status

10a. Stata

Director

Funeral

à

Completed

Be

2

Usual Rasidence of Decedant

1 Nevar Married 2 Married

3 Widowed 4 Divorced

Elamentary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

11th

20a. Mathod of Disposition

29b. Signature and litia of certifi

31. Data filed (Month, Day, Year)

30. Nama and addrass of person who con

Ilch

APR 2 6 2000

the Maryland death

if item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at filed within 72 hours after Hygiene. ther than "natural", permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event.

Saltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Hospital

Physician /Medical Examiner

Examiner hysician and the burial-transit attending physician Physician/Medical the signed by by Completed been certificate has septal or Attending Physician: Thours after death, neral Director: After this certificat y filled in by the funeral director, p Be To Certification: To the Hospital
within 24 hours a
To the Funeral C
completely filled edicai

		Q 2 1 TATE	CU CU VI	INAPOLIS, MD.	21401
23a. Part 1. Entar tha disaase, or cor shock, or haart failura. List only	nplications that caused tha daath. y ona causa on each tina.	Do not antar tha mode of	dying, such as cardia	or raspiratory arrest,	Approximata Interval Batwaan Onsat and Death
Immediata Causa (Finat disaasa or condition rasulting in death)	a	Myestile as a ponsequence of):	heart of	hilure	Unlivern
Sequentially list conditions, if any, laading to immediate cause. Entar Underfying Causa (Disease or injury that initiated avants resulting in death) Last	Due to (or a	Gurdie nu se a consequence of: Fz. chemi se a consequence of:	e lund	destine	
Part II. Other significant conditions Diah	contributing to death but not result	ing in tha undarlying cau	sa given in Part I.	23b. Dld tobacco use con	ntribute to the cause of death?
				24a. Was an autopsy performed?	24b. Wara autopsy findings evailable prior to completion of cause of death? 1 Yas 2 No
25. Was casa rafarred to medical			26 Place of De	ath (Check only ona)	
axaminar?	Hospital: 1 Inpatiant 2 E	R/Outpatient 3 DOA	Other	loma 5 ☐ Rasidanca 6 ☐ Oth	ar (Specify)
27. Manner of Death 1 Natural 5 Panding 2 Accident invastigation	(Month, Day Year)	28b. Tima of Injury M	Injury at Work? 1 Yes 2 No	28d. Dascribe how injury occurr	red
3 Suicide 6 Could not datarmine	28a. Placa of tnjury · At hom building, atc. (Specify)	na, farm, straat, factory, c	ffica	28f. Location (Street and Numb City or Town, Stata)	er or Rural Routa Number,
	hysician: To the best of my knowl miner: On the bests of examination and mining stated.				

State

Registrar

MD

usa of daath (ttam 23a) (Type, Print)

enun

32. Registrar's Signature

Shawn Monroe Hamilton

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	-3				
е	00	11	55	-	1
	00	3 4			0

			Certificate of	Death	Reg. No		10010
Physician	1. Decedent's Nama (First, Middla, Las	51)		2	Data of Death Month Da	v Yaar	3. Tima of Death
Physician /Medical	SHAWN M. HAMI				April 1	6 2000	12:25 P.M.
Examiner	4a Facility Nama (If not institution, give	a street and number) St 32nd Street		4b. City, Town, or Loca		. County of Death	
Funeral	5. Social Sacurity Number 6. S		st birthday) If Undar 1 Yaar	Baltimo	DITE Data of Birth (Month, Day, Year)	N/A 9. Birtho	place (Stata or Foraign
Funeral Director		MM 2□F 27	Yrs. Months Days	Hours Min.	(Month, Day, Year) ARCH 13	1973 IL	LINOIS
how thow	10a. Stata 10b. County	10c. City	, Town or Location			1	10d. Insida City Limits
vith the Ma or 28a-f s be notified	MARYLAND ANNE A	RUNDEL ANN	APOLIS				1 ☐ Yas 2 🛣 No
uth with the Marylen 23a or 28a4 show ant be notified at			10f. Zip Coda		10g. Cit	tizan of What Cour	ntry?
frer death v r freme 23s	1193 BAYVIEW V	12. Was Decedant Evar in U.S	2 1 4 3. 13. Was Decedant of	O 1 Hispanic Origin? (Speci ban, Maxican, Puarto Ri	fy Yas or No-	14. Race - Amaric	
by	3 ☐ Widowed 4 ☐ Divorced	Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	If Yas, specify Cui		can, atc.)	Black, Whita,	
21215-00) ed within 72 hours ygiene. er then "natural; ft, the Medical Ex	15. Decedant's Ed (Specify only highast gra	ucation da complated)	16a. Decedent's Usual Occu (Giva kind of work done lifa. DO NOT use ratin	pation a during most of working	16b. K	(ind of Business/In	
within within then then then then then then then the	Elemantary/Secondary (0-12)	Collaga (1-4or 5+)	'lifa. DO NOT use ratin	ed)		TERN PO	INT
d 2 Hygie ther the Co		0	Counsciol	18. Mothar's Nama (i		LTER Sumama)	
ylanc build be fi Mentel H arked oth artic ever	KENNETH HAMI	T.TON		DARLENE			
Maryla d 2 ahould th end Men 7 is marke treumatic	19a. fnformant's Name/Ralationship (19b. Mailing Addrass (Strae			or Town, Stata, Zip	Coda)
CENF	DARLENE HAMILTO		362 FOREST	BEACH RD			
Peges nent of int: if the iry or o	20a. Mathod of Disposition 1 Burial ZZ Cramation 3 4 Donation 5 Other (Specify	Ramoval from Stata MT	ace of Disposition (Nama of matary, cramatory or other place) TRO CREMATO		Data 20c. L	ocation - City or To	
Baltim Permit. Peg Department Important: 8 eny fnjury o pnce.	21. Signatura of Funaral Sarvice Licen	saa M00483		SE & SONS			
	23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	plications that causad the death.	. Do not antar tha mode of dy	T ST ANN	apolls,	MD. 214	Approximata Intarval Batween
Physician /Medical	Immediata Causa (Final		. 1	11.			Onsat and Daath
Examiner	disaasa or condition rasulting in daath)		Wound of	Head		<u> </u>	
in the second		Dua to (or	as a consaquance of):			1	
58760, cate be executed physician end s the burist-transit	Sequentially list conditions,	b Dua to (or	as a consequance of):				
60, be ex cician of burial	Sequentially list conditions, if any, laading to Immadiata cause. Entar Undarlying Causa (Disaasa or Injury	c					
68760, rificate be ev ng physician as the buria	that initiated evants rasulting in daath) Last	Dua to (or	as a consequance of):				
Box (settifest) seth certifest for use a		d					
BOX deeth cer e ettendir d for use	Part II. Other significant conditions or	ontributing to death but not resul	Iting in the underlying cause o	ivan in Part I.	23b. Did tobacco	usa contribute t	to the cause of death?
COrdS, P.O. Box 68760, requires that the death certificate be executed been signed by the ettending physician and should be detached for use as the burial-transit leted by Physician/Medical Examile					1 □ Yes 2	2 ⊠No 3□ Pro	obably 4 Unknown
Signed by by						1	
The lew requires the lew requires the less been signed, page 2 should be dempleted by					24a. Was an auto performed?	av	/ara autopsy findings vailabla prior to omplation of causa
Hec e lew hes b					Partial		daath?
of Vital Records, Physician: The lew requires the cartificate has been signed rail director, page 2 should be. TO Be Completed by.	25. Was casa rafarred to medical		PART CA	00 Dian (D at)	100	No 1	Yas 2□ No
Of VITa Physician: rithis certific oral director,	axaminar? 1 ☑ Yas 2 ☐ No	Hospital: 1 ☐ Inpatiant 2 ☐ E	ER/Outpatient 3 DOA	26. Placa of Death (5 ☐ Rasidance	6 NOther /Speci	ify) Scope
g Phy g Phy er thi	27. Mannar of Death		28b. Tima of 28c. Injury W		d. Dascribe how inju	ry occurred	
Attending r death. Actor: After fune by the fune iffication	1 Natural 5 Panding 2 Accident invastigation	4-16-00		Yas 2 No S	elf inflict	ed guns	hot wound
DIVISION C tel or Attending P is after death. el Director: After b led in by the funers Certification:	3 Suicida 6 Could not be datarmined	28a. Place of Injury - At hor building, atc. (Specify,	ma, farm street, factory, office	28	f. Location (Street a City or Town, State	nd Number or Run	al Routa Number, 2 hd Street
Hospital 24 hours a Funerel Eletely filled	29a. Cartifiar 1□ Certifying Ph	ysician: To the best of my know	street	time data and place as	altimore,	M	stated
DIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely illed in by the funeral di Medical Certification: To		Iner: On the basis of axaminati and mannar stated.					
Within To the comp	29b. Signatura and titla of certifiar	- 0.0	29c. Licar	nsa number	29d. Da	ata signed (Month,	Day, Year)
	Clemi	2 Chertino		O.C.M.E.		April 17	7, 2000
3.50	30. Nama and addrass of person who	ompleted causa of daath (Itam					
	31. Data filed (Month, Day, Year)	32. Registrar's Signati		Street, Ba	ltimore, M	Maryland	21201
State Registrar	APR 2 0 20		G. Span	6			

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

	C AACO Health Dept	4/21/00 c	m Certificate	of Death		Reg. No.	
Physician	1. Decedent's Neme (First, Middle, Last)	L. Joh	DSEN 7	1	2. Data of Date Month	Day 2 Yes	3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, give street		130N -		r Location of Death	4c. County of D	
	BON SECOURS HOSPI	TAL	ALC: YELL	BALTIMO			RUNDEL
eral ctor	5. Social Security Number 6. Sex 212-78-6577	7. Age (In yrs. last	Yrs. If Under 1 Months I	Yaar If Undar 24 Hi Days Hours Min		1960 MA	Birthplace (State or Foreign Country) ARYLAND
	Usual Residence of Decedent 10a. State 10b. County	10c City 1	own or Location				10d. Inside City Limits
20	MARYLAND ANNE ARUN		POLIS				MoXyes 2 □ No
Funeral Director	10e. Street and Number 1879 BOWMAN COURT		10f. Zip Ci	ode 401	W-1	10g. Citizen of What USA	Country?
by Funer	1 Never Married XIXMarried 1.	as Decedent Ever in U,S. med Forces? Yes 2X No fes, Give lar or Dates:	13. Was Deceder II Yes, specify	nt of Hispanic Origin? (Cuban, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	Black, W	merican Indien, /hite, etc. BLACK
Be Completed	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12)		6a. Decedent's Usual ((Give kind of work life. DO NOT use	done during most of w	orking	16b. Kind of Busine	ss/Industry
3	10th ()	TRUCK			E.L. GARI	ONER
Be C	17. Father's Name (First, Middle, Last)	OM CD			ame (First, Middle,		
2	JUNIOR L. JOHNSO 19a. Informant's Name/Relationship (Type, Pr		19b. Mailing Address (S		ETTE HOW		e, Zip Code)
	DENISE JOHNSON (WI		1879 BOWM				1401
	20a. Method ol Disposition 1⊠ Burial 2 □ Cremetion 3 □ Remove 4 □ Donation 5 □ Other (Specify)	cem	e of Disposition (Neme etery, crematory or othe L CREST C	er place)	Date 4/20/00	20c. Location - City ANNAPOL	
fedical Examiner	23a. Part1. Enter the disease, or complication shock, or heart leilule. List only one ceu Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last	SEPTIC Due to (or a BRONCHO Due to (or a ACQUIRED	SHOC s a consequence of): PNEU s a consequence of):		ac or raspiratory a	rest,	Approximate Interval Between Onset and Deeth
Completed by Physician/M	Part II. Other eignificant conditions contributi	0 7	ng In the underlying cau				oute to the cause of death? Probably 4 Dunknown
eted by	CARIOMYOPATI	GENAL L	DISCASO			en eutopsy 24 rmed?	tb. Were autopsy lindings available prior to completion of causa
1					10	Yes 200No	of deeth?
Be	25. Was case referred to medical			26. Place of D	eath (Check only o	,	7-4-0
2	examinar? 1 ☐ Yes 2 No Hospita	al: 1 Nnpatient 2 ☐ EF	VOutpatient 3□ DOA	Other: 4 Nursing	Home 5□ Resi	dance 6 Other (5	Specify)
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Certific	3 Suicida 6 Could not be determined 286	e. Plece of Injury - At home building, etc. (Specify)	e, farm, streat, factory, o	office	28f. Location (City or To	Street end Number o wn, State)	r Rural Route Number,
=	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: O						
dic			29c. l	License number		29d. Date signed (M	Ionth, Day, Year)
Medical	29b. Signeture and title of certilier		2			11	
	J.A. Hamilton M.	D. Med. Sta		08291		4-15	-2000
	29b. Signeture and title of certilier A. Hom, Hon M 30. Nama and address of person who complet Bay Securs Hospi	ed causa of death (Item 2)		08291	BALTIM	4-15 URE, MD	-2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year April **Physician** Phebe Jacobs en 2000 5:00 am /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner 735 Glenwood Street Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 579-14-3910 1□M 25 F 78 Yrs Director March 24,1922 Maryland Usual Residence of Dacedant with the Marylend 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryle pagariment of Heelth and Mental Hygiene. Important: if fem 27 is marked other than "nature!, or flems 23a or 28a-f show they hipty or other treumstic event, the healtest Examine main be notified. 1 Ves 2 □ No Annapolis Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 Funeral 735 Glenwood Street USA 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 4 College (1-4or 5+) Elementary/Secondary (0-12) Archivist State Government 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Orris G. Robinson Dorothy Medders 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Eric Jacobsen, Jr/ Grandson 1150 Riverview Dr. Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 04-20-00 Brentwood, MD 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Fineral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final diseasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner lew requires that the death certificate be executed ettending physician end for use as the buriel-trens Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that is its today or Injury P.O. Box 68760. that initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3010 3 Probably 4 Unknown 1 Yes Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas Hypertersen certificete Division of Vital Hospital or Attending Physician:
24 hours efter death.
 Funeral Director: After this certifice director, 25. Was cased referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 200 No 2 1 Yes 27. Manner of Daati 28c. tnjury at Work? 28a. Date of tnjury (Month, Day Year) Certification: 28b. Tima of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be datarmined 28e. Place of tnjury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State

edical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

586 Bellerive Drive, Suite 2B, Annapolis, MD 2140, Patricia O'Hora, M.D. 32. Registrar's Signatura APR 2 0 2000

and manner stated.

30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)

12 Certifying Physictan: To the best of my knowledga, daath occurred at tha time, data and place, and due to tha causa(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

To the Hosp within 24 hou To the Fune completely fi

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year **Physician** CARVILLA KNIGHT ELIZABETH April 2000 1705 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Yrs Director 212-30-1061 MAY 29, 1915 MARYLAND **Usual Residence of Decedent** permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: if Itam 27 is merked other than "natural", or thems 23s or 28s-1 show eny injury or other traumatic avent, the Medical Examinal must be notified at Page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND TALBOT EASTON Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 U.S.A. 941 PORT STREET Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 ☐ Merried Specify: WHITE Baltimore, Maryland 21215-0020 1 Yes 2XXNo Specify: Š 31 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION WORKER ICE CREAM UNKNOWN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be SOPHIA HERBERT COX 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 893 TIMBER RIDGE DRIVE, HANOVER, MARYLAND 21076 MR. WILLIAM KNIGHT (SON) Date 200 0 20c. Location - City or Town, State 20b. Ptece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 Cremetion 3 Removal from Stete GLEN HAVEN MEMORIAL PARK GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1700303 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Do He Vari 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Severe ARtery CORONARY Examiner Due to (or es a consequende of): Examiner DiAbetes The law requires that the death certificate be executed buriel-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Hypertension P.O. Box 68760. Physician/Medical Due to (or es a consequence of): use as the Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown Records, 2 24b. Were autopsy findings eveilable prior to Completed 24a. Wes an autopsy completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physicisn: funeral director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7.000 le emyno Dunc D0053236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. HELMLY, 403 MARVEL COURT, EASTON, MARYLAND 21601 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar APR 2 0 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Daath Day Month Yaar KUBRE ROBERT 26 2000 0430 AM 04 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Montgomery General Hospital Olney Montgomery If Undar 1 Year | if Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Birthpiaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) Days Year) Hours 15€M 2□ F 82 Yrs. 12/02/1917 577 16 2875 Washington DC Usual Residence of Decedant 10c. City, Town or Location 10b. County 10d. Insida City Limits ... 1 Yas 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citlzan of What Country? 20906 USA 3642 Glen Eagles Drive #1G 12. Was Dacedant Evar in U.S. Armed Forcas? 10/12 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, spacify Cuban, Maxican, Puarto Rican, atc.) Race - American indian, Black, White, atc. No Printed Forcas? 1943— 1 Transport 1943— If Yes, Giva Yaar or Datas: 1946 1 Navar Marriad 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Pivorced 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16h. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Business Owner Radiator Shop 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Lizzie Gerber Harry Kobre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 160 Kirwan's Landing Lane, Chester MD 21619 Karin Larsen/daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Metropolitan Crematory 4/27/00 Alexandria VA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licansea 22. Nama and Addrass of Facility Advent Funeral & Cremation Services Vagguer Annapolis MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat end Death Immadiate Ceuse (Final SEPTICEMIA WEEKS disaasa or condition resulting in deeth) Dua to (or as a consequence of) WEEKS CELLULITIS Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or injury Dua to (or as a consequance of) thet initiated events resulting in death) Last Dua to (or es a consaquance of) 23b. Did tobecco usa contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENTE FAILURE, CEREBROYASURUAL 24b. Wera eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy ACCIDENT ellocecysnois 1 Yes 28 No 1 ☐ Yas 2 No 25. Was casa rafarrad to medical 26. Pleca of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1. Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed attending physician and for use as the bunal-tran Records, P.O. Box 68760, signed by the a peen has le 2 certificate Division of Vital director this After this death. after death Director: A d in by the f

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23 any Injury or other traumatic event, the Medical Experiments".

Physician /Medical

Examiner

Physician/Medical Examiner

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Certification:

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Baltimore, Maryland 21215-0020

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Hospital or Attending Physician: in 24 hour. the Funeral Directory filled in To the I within 2 To the I complet

29a. Certifiar 🔀 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es steted. (Check only one) 29b. Signatura and titla of certifier

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29c. Licensa number

Farry Deely

019192

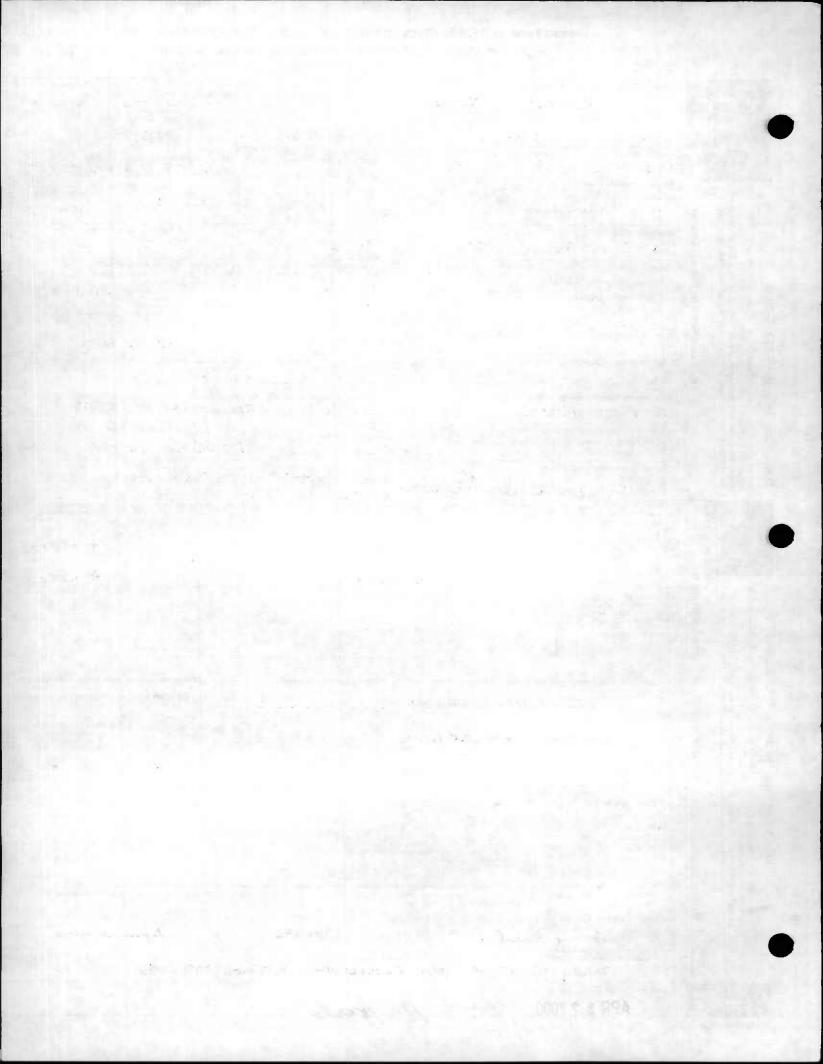
29d. Data signed (Month, Day, Year) April 26, 2000

30. Name end eddrass of person who completed cause of death (Itam 23e) (Type, Print)

HEEHE, MD 3941 FEDRALA DRIVE WHEATON MID 20906 BARRER

State Registrar

31. Data filad (Month, Day, Yaar) 7 2000 32. Ragistrar's Signatura sports



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	Funeral Director	5. Social Security Number 212-20-7461	6. Sex 1 → M 2 □ F	7. Age (In yrs. last bir	thday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Feb. 2,	Year) 1923	Coun	lace (Steta or Foraign try) /land
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	r froms 234	2065 D Glen Co	12. Was Dec	sedent Ever in U,S.	13. Was Decedent of	21034 Hispanic Origin? (S	pecify Yes or No-	14. Rac	USA e - Amaric	an Indian,
	or its		Armed Field XXX Yas If Yes, G Year or I	orcas? 2 No iva Datas: 1943-45	If Yes, specify Cu	ban, Mexican, Puert o Specify:	o Rican, atc.)	Specify Specify		eic. nite
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0	permit. Departr Importu eny inji	.711.11.11	16	1	Maclama	Themana I I	Home, P.A	A.		
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29a. Certifier (Check only Check only 20 Medical Examiner: On the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) end manner es stated. 20 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause (s) end manner es stated.	Number,				
and manner stated.					
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	ar)				
Butte & Malla Man D50157 April ZY Z	200				
30. Name and addysss of person who completed ceuse of death (Item 23e) (Type, Print)					
Birgitta E Miller MD 8601 Veterons Highway Suite III Millersville 14	D				
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State 31. Date filled (Month, Day, Year) Registrar APR 2 5 2000					
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death AMOCIC Physician 2000 1820 ERBEKT 04 /Medical 48 Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNAPOUS MINNE If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days 10 M 2□ F Mary Land Sept. 220-09-3358 Director 80 Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryla Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahov any injury or other treumatic avent, the Medical Emerical must be notified at Page. 1 ☐ Yes 2 No Director Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1931 Pendennis Drive 21401 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 △ Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bleck, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Giva Year or Dates: 1944-46 1 ☐ Yas 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Building Industry 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Paul O. Mamock Helen Hollman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Katherine Mamock/ Wife 1931 Pendennis Drive Annapolis, Maryland 21401 20b. Place of Disposition (Nema of cematery, crematory or othar place, 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata 04-24-00 4 ☐ Donation 5 ☐ Othar (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral San ce Lio 22. Nama and Addrass of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervet Between Onsat and Death **Physician** Concer, Metastati Immediate Causa (Finat disaasa or condition rasulting in death) /Medical Examiner Due to (or es a consequança of): Physician/Medical Examiner sicien and buriai-frensit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated events rasulting In death) Last Due to (or as a consequence of): P.O. Box 68760, the Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pe de l Records. þ Be Completed 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? complation of cause of death? cate has 1 Yas 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Time of After 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No invastigation 6 ☐ Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation in my existing death account. 29a. Certifier Medical

State Registrar

APR 2 5 2000

(Check only one)

32 Registrar's Signature

iner: On the basis of axamination end/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Casey James Hunter Smyth 2000 7:00am April 26 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 331 South Deen Avenue
5. Social Security Number 6. Sex Aberdeen Harford If Linder 8. Date of Birth (Month, Day, Year) 02/14/1999 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Yrs. Director 220-53-6722 Usual Residence of Decedent with the Marylend permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show pintry or other traumatic event, the Medical Examine must be notified at ends. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Directo MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 331 South Deen Avenue 21001 Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Tammie Lee Newman Wark Allen Smyth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 S. Deen Ave., Aberdeen, MD Mark A. Smyth- Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Fremont Cemetery 4/29/00 Pennsylvania 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, i√.D 21078 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 11 months cerebellar spendymoma Examiner Due to (or as a consequence of) Examiner ettending physician and for usa es the bunel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of) signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? page 2 s is certificate h 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by tha funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after daeth. Funeral Director: After this certifica To the Hospital within 24 hours a To the Funeral C completely filled

State

Registrar

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4 Homicide

(Check only one)

29b. Signature end title of certifier Kon

31. Dete filed (Month, Day, Year)

MAY

29a. Certifier

30. Name and address/of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St RM NSEIB Baltimore MD 21201 Kaveri Sunyanarayan MD

2000

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32. Registrar's Signature

Souls

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner as stated.

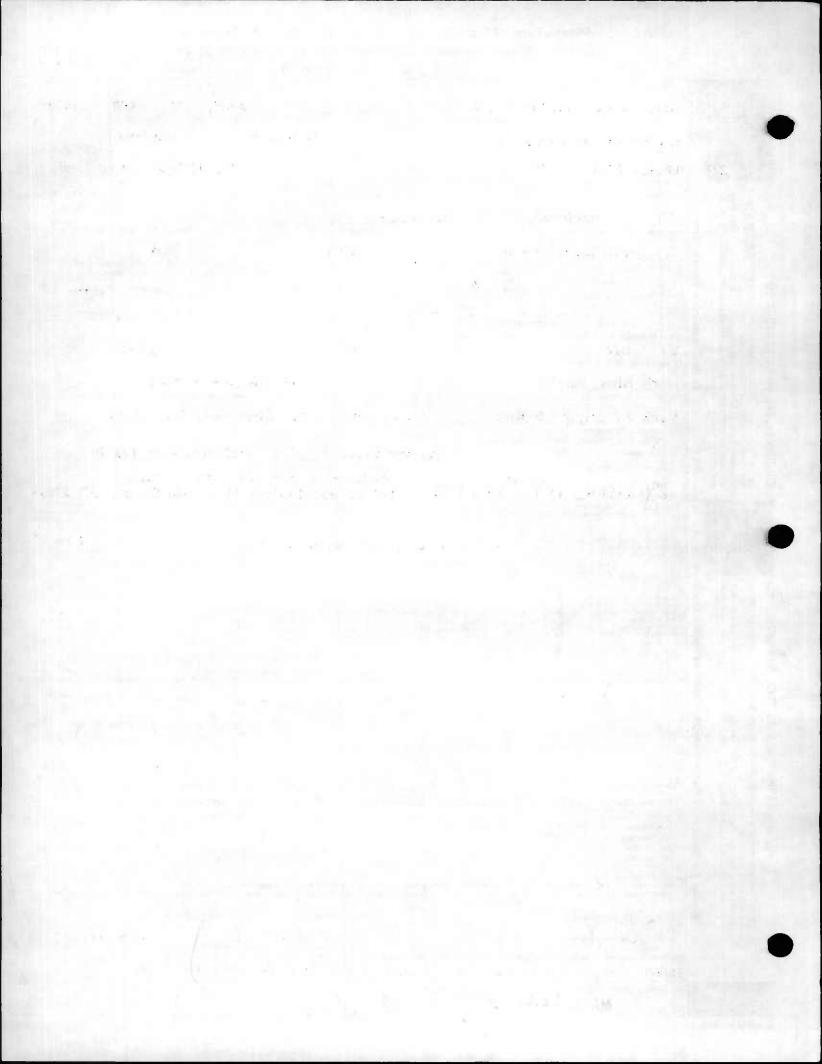
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

D0055194

29d. Date signed (Month, Day, Year)

4/27



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Month Day H. Chapline Staley. Jr. April 29, 2000 10:40 pm 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center Mallard Bay Nursing & Rehabilitation Cambridge Dorchester 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Data of Birth 9. Birthplace (State or Foreign (Month, Day, Yaar) 1910 Maryland Months Days Hours 216-05-0361 89 Usual Rasidance of Decedant 10b County 10c. City. Town or Location 10d. Insida City Limits Maryland Dorchester Cambridge 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5617 Cassons Neck Rd. 21613 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 2 No If Yas, Giva Year or Datas: 14. Raca - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: 3 Widowad 4 ☐ Divorced White 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Commercial Belt Elamentary/Secondary (0-12) Collage (1-4or 5+) 12 Owner Manufacturing 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) H. Chapline Staley, Sr. Lilian Stevens 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Route Numbar, City or Town, State, Zip Coda) Barbara S. Field/Daughter 604-3 Water St., Cambridge, MD 21613 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Cambridge Crematory 4-30 Cambridge, MD 22. Nama and Addrass of Facility Curran-Bromwell Funeral Home, P.A. 21. Signature of Funeral Service Licensee 208 High St., Cambridge, MD 21613 Later the dischase of complications that caused tha death. Do not antar the mode of dying, such as cardiac or raspiratory errest, Applications that caused on each line. Approximete Interval Batween Onsat and Daath Immediata Cause (Final disaasa or condition rasulting in daath) Aspiration preumon 12 30 m.w Dua to (or as a consequence of): Chronic Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants Due to (or as a consequence of) rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown encephal opath 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? N/A s 20 No 1 Yes 2 Did 1 🗆 Yes 26. Placa of Daath (Chack only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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be filed within 72 hours efter de tal Hygiene. d other than "naturel", or item event, the Med cal Examiner i

permit. Pages 1 end 2 should be filed v. Depertment of Health end Mental Hygiel important: if item 27 is merked other the any injury or other treumatic event, the page.

Baltimore, Maryland 21215-0020

Director

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The law requires that the deeth certificate be executed use as the buriel-trensi page 2 should be or Attending Physicien: this

Box 68760.

P.O.

of Vital Records,

Division

Physiclan/Medical Examiner Certification: To s efter deeth.

I Director: After this od in by the funeral d filled in by

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25. Was casa ratarred to medical axaminar?

27. Mannar of Da th

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(Check only one)

29b. Signatura and titla of cartifian

3 ☐ Suicida

29a. Cartifian

1 Yas 2

5 Panding investigation 6 Could not ba

1 ☐ Inpatiant 2 ☐ ER/Outpetiant 3 ☐ DOA Data of injury (Month, Day Year)

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28b. Tima of

1 ☐ Yes 2 ☐ No

Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

000

211284

29d. Data signed (Month, Day, Year)

30. Name end address of person who complated causa of death (Itam 23a) (Type, Print)

ANN Kobinson MD Nilke

31. Data filed (Month

32. Ra estrar's Signatura

400 Maryland AUZ Combudge MD 21613

28c. injury at Work?

29c. Licansa number

State Registrar

Medical

To the Hospital of within 24 hours of To the Funeral D completely filled in

Andrew Sycological St.

MAY 22 YAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 15520

			C	ertificate of	Death		R	leg. No.	
	1. Decedent's Neme (First, Middle, La	est)					2. Dete of Dea Month	th	3. Time of Death
Physician /Medical	Werner	George	Schnoor				April	19, 200	0 9:29 AM
Examiner	4e Facility Neme (If not institution, gir	re street end number)			4b. City, Tox	wn, or Lo	cation of Death	4c. County of E	Deeth
	Anne Arundel Medi	cal Center			Annapo.			Anne Aru	ndel
Funeral Director		Sex 7. Age 7. A	(In yrs. last birthda 7 Yrs.	Months Deys		24 Hrs. Min.	8. Dete of Birth (Month, Dey Januar		Birthplace (Stete or Foreign Country) Germany
8 8	Usuei Residence of Decedent 10a. Stete 10b. County		10c. City, Town or	Location					10d baids Ob timbe
sho sho dat									10d. Inside City Limits 11 Yes 2 □ No
or 28a-f i be notified Directo	Maryland Anne Ar	under	Annap					0 - Oist 6 147	
	215 McKendree Ave	nue		10f. Zip Code 214	01	. 1		Og. Citizen of What United St	
ar, or he Esamine by Fur	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ex Armed Forces? 1 Yes 27 No if Yes, Give A Yeer or Detes:		i. Wes Decedent of If Yes, specify Cul 1 ☐ Yes 2 🏋 No		gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Americen Indien, Vhite, etc. White
we than "neturn tr, the Medical. Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usuel Occu	pation	of worki	ina	16b. Kind of Busine	ess/Industry
within one the Med	Eiementery/Secondery (0-12)	College (1-4or 5+	life	re kind of work done DO NOT use retin		Of WORK	''9		
Con the	12			Boat J				Ship Bu	ilding
Be seath	17. Fether's Neme (First, Middle, Last)			18. Mothe	r's Name	(First, Middle, i	Me <i>iden Sum</i> eme)	
Menid Menid marks affic To	Ernst Schnoo	r			Max	rie B	urmeiste	r	
2 sh and sh m	19a. Informant's Neme/Reletionship (**		iling Address (Stree					te, Zip Code)
and bailth n 27 wer tr	Janet Schnoor/ W	ife		5 McKendree	Avenue	Ann	apolis, M	d. 21401	
T C H	20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □	Damovel from State	20b. Piece of Dis	position (Neme of emetory or other pla	ece)	1	Date	20c. Location - City	or Town, Stete
Pages ment of mrt. If No	4 ☐ Donetion 5 ☐ Other (Special		Cedar Blu	ff Cemetery		04	-24-00	Annapolis,	Maryland
mit. ponty inj	21. Signeture of Europe Service Lice	nsee		22. Name end Addr	ess of Fecility	y Jo	hn M. Tay	lor Funeral	Home, Inc.
89188	1 1 Konstant			147 Duke	of Glo				s, Maryland 214
	23a. Pert1. Enter the diseese, or com shock, or heert failure. List only	plicetions thet ceused to	he deeth. Do not e						Approximete intervei Between
ficate be executed physician and ts the bunal-transit edical Examiner	Sequentially list conditions,	b	ue to (or es e cons ue to (or es e cons			P.			
cartificate be executed ving physician and use as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	ue to (or es e cons	editable of).					
E	resulting in death) Lest	d	20 (0/ 03 0 00//36	squence ory.					
that the died by the detached	Pert II. Other algnificant conditions of	ontributing to death but	not resulting in the	underlying cause g	iven in Part I.		23b. Did to		oute to the cause of death Probably 4 Unknow
9 20 0	Ischem	e card	comyop	thy		_	24a. Wes e		4b. Were autopsy findings evailable prior to completion of cause of deeth?
yatclan: The lev is certificate has director, page 2 fo Be Comp							1 🗆 Y	es 2000	1□Yes 20 No
entific ector, Be	25. Was cese referred to medical examiner?				26. Place	of Deeth	(Check only or	ne)	
5 00	1 Yes 2 No	Hospitei:	2 ☐ ER/Outpati	ent 3 DOA	ther: 4 Nu	rsing Ho	me 5 Resid	ence 6 Other (Specify)
Attending Ph or deeth. ector: After th by the funeral	27. Manner of Death Natural 5 Pending 2 Accident investigatio	28e. Date of Injury (Month, Dey		Wo	ury et ork?]Yes 2 ☐ f		28d. Describe h	ow injury occurred	
tel or Attending P rs after deeth. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc.	y - At home, ferm, s (Specify)	street, factory, office			28f. Location (S City or Town		r Rural Route Number,
he Hospi in 24 hou he Funer plately fill edical	29a. Certifier (Check only one) 1 Sertifying Pt 2 Medical Example (Check only one)	ysician: To the best of niner: On the basis of e end menner stete	xamination and/or	ath occurred at the t investigation, in my	ime, date and opinion, deat	d place, o	end due to the c ed at the time, d	ause(s) and menne late and place, and	or as steted. due to the cause(s)
withi vithi To th com	29b. Signature end title of certifier	(4)	timec Yu	1 05	5 (&	37		Ped. Date signed (A	onth, Day, Year)
	30. Name and address of parson who	c Ct	oth (item 23a) (Type	p, Print)	4, 2	10	214	O (Aime	e Yu
State Registrar	31. Dete filed (Month, Dey, Year) APR 2 0 200	32 Registrer	s Signeture	Spark	2				

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗋 🦳 5521 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dav Month Year **Physician** 26, DON EDWARD TESTERMAN April 2000 4:34 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Street 3530 Mill Green Road HArford If Undar 1 Yaar if Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 2 F Yrs 231-24-3099 Director 72 2/1/1928 Virginia Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Depertment of Health end Mentel Hyglene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evantment must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes ZNo Directo MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21154 USA 3530 Mill Green Road Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) Raca - Americen Indian, Black, White, etc. 1 ☐ Yes ★★No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0020 1 ☐ Yes → No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middla, Malden Sumeme) 17. Father's Name (First, Middle, Last) Be Neal M. Testerman 2 Cloie Stone 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty C. Testerman -wife 3530 Mill Green Rd., Street, MD 21154 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Nebo Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/30/00 Delta, PA 21. Signature of Funaral Servica License 22. Name and Address of Facility Harkins F.H.Inc., 600 Main st.Delta, PA 23a Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ASLUD Examiner Due to (or as a consequence of): Physiclan/Medical Examiner physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760, Dua to (or es a consequence of): usa as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypothyvoidism. Records. þ 24b. Ware autopsy findinga available prior to completion of causa of death? Completed 24e. Was an autopsy r this cartificate has aral director, pege 2 1 Tyes 2 □ No 1 Yes XXX No Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this cartificately filled in by the funeral director, Be 25. Was cese referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX es 2□ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatlant 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. edical 29a. Certifier 29d, Date signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of certifier

12

State Registrar 4PNAGHU MD
31. Date filed (Month, Day, Year)

APR 2 7 2000

72. Registrar's Signature

30, Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

DMG

Sparks MD ZIOIY

DCME

4/27/2000

410-879-6564

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Year Robert A. Waltsak 22 2000 4c. County of Death 8:15 PM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Heritage Harbor Nursing Home Annapolis Anne Arundel 8. Dafe of Birth (Month, Pay, Year) May 31, 1921 If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) New Jersey 6 Sex 7. Age (In yrs. last birthday) Days Hours 1₩ 2□ F 78 Yrs. 136-12-3375 Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 695 Americana Drive 21403 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White WWII 1 ☐ Yes 2 No Specify 3 DWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) yrs, Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Martin William . Waltsak 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 22227 North Oak Ct. Arlington, VA Mary Anne Perko/daughter 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from Stata 4/27/00 East Hanover, NJ Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility 21. Signatura of Funeral Service Licensee John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death Immediate Cause (Finat disease or condition rasulting in death) Due to (or as a consequence of Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Dthknown

Physician /Medical Examiner

physician and s the bunal-transit

signed t

page 2

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p.

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital

Physician

/Medical

Examiner

Directo

Funeral

Completed

Be 2 10a. Stefa

Funeral

Director

28a-f

8 Nerna 23a

permit. Pages 1 and 2 ahould be filed within 72 hours after Cepatiment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Examina

Saltimore, Maryland 21215-0020

Physician/Medical Examiner þ Completed Be 1 Yes 2 No Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated exercises) fhat initiated events resulting in death) Last

27. Manner of Death

1 Naturat

2 Accident

3 Suicide

4 Homicide

25. Was case referred to medical

Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

24a. Was an autopsy performed?

1 Yes 2 No

24b. Wara autopsy tindings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

spitat: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 D Nursing	Home 5 ☐ Rasidance 6 ☐ Othar (Spe	ocify)
28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
28e. Placa of Injury - At h building, atc. (Special	oma, farm, stree	t, factory,	office	28f. Location (Street and Number or R City or Town, State)	ural Route Number,

29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	my knowledge, daath occurred at tha time, data and place, and o examination and/or invastigation, in my opinion, daath occurred a ed.	due to the cause(s) and manner as stated. I tha time, date and place, and dua to the d
29b. Signature and fille of certifier	29c, License number	29d. Date signed (Month, Day,
N. IOWAKON M.V	1241978	4-23-2

5 Panding investigation

6 Could nof be determined

On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha time, date and place, and dua to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Neme and eddress of person who completed cause of death (ttem 23a) (Type, Print) TavaKoli M.I) 3001

HUSI IN Chevely M.1 20785

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 2 5 2000 32 Regisfrer's Signeture

DHMH 16 Rev 6/95

State Registrar SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print)

32. Regigtrar's Signeture

31. Dete filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Isabel Ellen Ward April 18 2000 6:50 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplaca (State or Foreign Country) **Funeral** Months Days Min. Hours 1 M 2 TF Director 216-16-4102 74 Maryland Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Directo MD Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 24110 Carrlyn Drive 21660 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: à 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital Pages 1 end 2 should be filed v iment of Heelth end Mental Hygie lant: If itam 27 is marked other ti jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Frank Ridgeway Ellen Sears 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) William H. Ward / Son 605 Oakland Hills Ct. Unit#401 Arnold, MD 21012 20b. Piece of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-21-00 Davidsonville, MD. 4 ☐ Donation 5 ☐ Other (Specify) All Hallows Chapel Cem. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Servica Licent 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner attending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be Physician/Medical Due to (or as a consaquanca of): signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy been certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 -No 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) Certification: 27. Menney of Death 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred i or Attending F Division 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 ☐ Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - Al homa, farm, streel, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Phyelclen: To the best of my knowladge, death occurred at tha time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edicai 29b. Signature and title of continue 29d. Date signed (Month, Day, Year) 29c. License number my completed causa of death (Itam 23a) (Type Print) 30. Name and

Registrar

State

31. Date filed (Month, Day, Year)

APR 2 0 2000

32. Registrar's Signeture

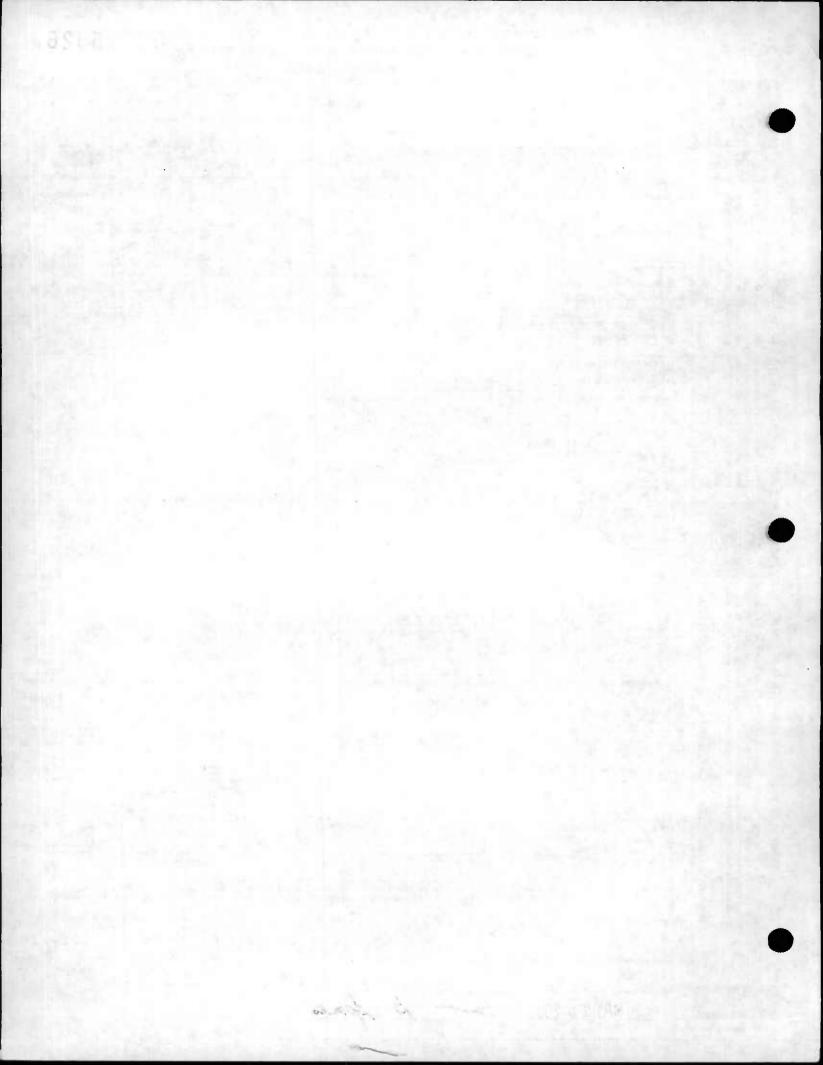
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** ALBERT WATKINS

4e Facility Neme (If not institution, give street end number) /Medical 4b. City, Town, or Location of Deeth 4c 2000 2:00 am 4c. County of Deeth Examiner ARNOLD ANNE ARUNDEL 1274 HARDY ROAD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 120 M 2□ F Yrs Director 215-30-3028 Usuel Residence of Decedent 65 SEPT. 20 1934 MARYLAND 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No notified Director MARYLAND ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 25 1274 HARDY ROAD 21012 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. natural, or hame Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus filed within 72 hours after 1 Never Merried 20 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7th LABORER SELF EMPLOYED permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if them 27 is marked other any Injury or other tra-17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ISAAC WATKINS ALVERTA EASTON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ALICE WATKINS (WIFE) 1274 HARDY ROAD ARNOLD, MD. 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete HILL CREST CEMETERY 4/22/00 ANNAPOLIS, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee MOO483 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 21401 Approximate Interval Between Onset and Deeth Reese 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of): Physician/Medical Examiner lan The law requires that the death certificate be executed ician and burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last consequence of): P.O. Box 68760. the Due to (or es a consequence of): for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? ate has been signed by page 2 should be datac 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 → No Medical Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affer 5 Pending investigation 1 ANaturat death. 1 □ Yes 2 □ No 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only within 2 To the 29b. Signeture end titte of certifier 29c. License number 29d. Date signed (Month, Dey, Year) un 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Annapolis (Tams 600 Ridgely 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State APR 2 0 2000 Registrar

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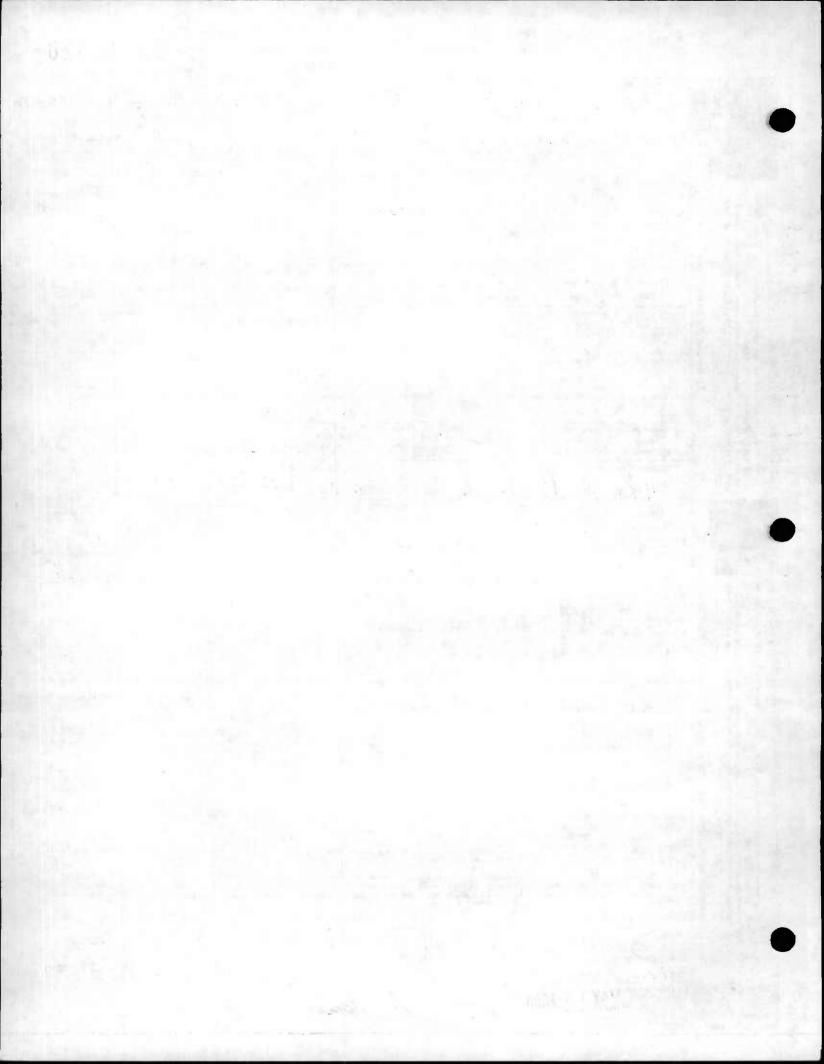
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	3	ate of Maryland / Do	Certificate of		ritai mygiei Reg. t		10021
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/Medical Examiner	4a Facility Neme (If not institution, give street			4b. City, Town, or Loca		tc. County of Dea	
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Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthe	day) If Under 1 Year		. Date of Birth (Month, Day, Yea	· · · · · · · · · · · · · · · · · · ·	rthplace (Stete or Foreign
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4	30. Neme and address of person who comple	Lal Dal IIII	ype, Print)	PARRWAY	DAM	IMAD :	= MAD
State	31. Date tited (Month, Day, Year)	32. Registrar's Signeture	163114	I HAIL WHY	DIFU	אטויוו	11410
Registrar	MAY 1 5 2000 B	mente & A	boaks				

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	State of Marylan	Certificate of Death	Reg. No.
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Examine Funeral Director	4a Facility Name (If not institution, give street and number) FROM KLINE SOUGHE ASSP 5. Social Security Number 6. Sex 1 XM 2 F 80	itsel Conta Rosev	
9 .	Usual Residence of Decedent	y, Town or Location	10d. Inside City Limits
Maryt el sho		Dundalk	1 ☐ Yes 2√2 No
	Maryland Baltimore 10e. Street and Number 7516 Durwood Rd.	10f. Zip Code 21222	10g. Citizen of What Country? USA
五00	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Vidowed 4 Divorced	S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexicen, Pue 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- rlo Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-C 21215-C within 72 h within 72 h bens.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 1 2	16a. Decedent's Usuef Occupation (Give kind of work done during most of we life. DO NOT use retired) Display Spec.	orking 16b. Kind of Business/Industry MUSEUM
C = 838	17. Father's Name (First, Middle, Last) James Bobart	18. Mother's Na	ame (First, Middle, Maiden Sumame) ne Williams
Mar Mar Mar Mar Mar Mar Mar Mar Mar Mar	19a. Informant's Neme/Relationship (Type, Print) Cecilia Bobart (Wife)	7516 Durwood Rd. Balt	Rural Route Number, City or Town, State, Zip Code)
Baltimore semit. Pages 1. Jepartment of Ha mportant: if Isen my Injury or oth		Place of Disposition (Name of Pametery, cremetory or other place) rdens Of Faith Cemetery	Dale 20c. Localion - City or Town, Stale 5/17/2000 Baltimore, Md.
Ball permit Depart Import any inj ansa	21. Signature of funeral Service Licensee	22. Name and Address of Facility Bruzdzinski Fune 1407 Old Eastern	eral Home P.A. n Avenue Essex, Md. 21221
Physician /Medical Examiner	23a. Park. Enter the disease, or complications that caused the deet leads, or heert feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) e.		Approximate Intervei Between Onset and Deeth
68760, filcate be executed physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or es e consequence of): Of SEASE or es a consequence of): r as a consequence of):	20 years
O. B. Be death the atterned for	Part II. Other significant conditions contributing to death but not rest	ulting in the underlying ceuse given in Part I.	23b. Did tobacco use contribute to the cause of death?
cords, P.O. Box v requires that the death cer been signed by the attendir should be deteched for use	Myo CARDIAN INFA	pretion	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box or Attending Physician: The lew requires that the death certained this certificate has been signed by the attending in by the funerel director, page 2 should be deteched for use			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of dealh?
of Vitai Re			1 Yes 2 No 1 Yes 2 No
of Vita hysician his certifu	25. Was case referred to medical examiner? 1 Yes 20 No Hospital: 1 Inpetient 2	Other	eeth <i>(Check only one)</i> Home 5 □ Residence 6 □ Other <i>(Specity)</i>
Vision of Vita	27. Menny of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred
Division of To the Hospital or Attending Phwithin 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral bases.	3 Suicide 6 Could not be determined 28e. Plece of Injury - At ho building, etc. (Specify		28f. Location (Street end Number or Rural Route Number, City or Town, State)
e Hoep n 24 hou e Funer sletely fil	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	wledge, deeth occurred at the time, date and plection and/or investigation, in my opinion, death occ	e, end due to the cause(s) end menner es stated. urred et the time, date and place, and due to the cause(s)
To th within To th comp	29b. Signature and the of certifier	29c. License number	29d. Date signed (Month, Day, Year)
4x1	30. Name and address of person who completed ceuse of death (ftem	123a) (Type, Print)	MAY 14, 2000 BALLMODE, MO 21237
	Stev 6n Mas 6n 9000 Man 31. Date filed (Month Pay, Year) 32. Registrar's Signa	KLI S DUAME DAIVE	· BALLMORE, MO 21237
State	MAY 1 5 2000	· A local	

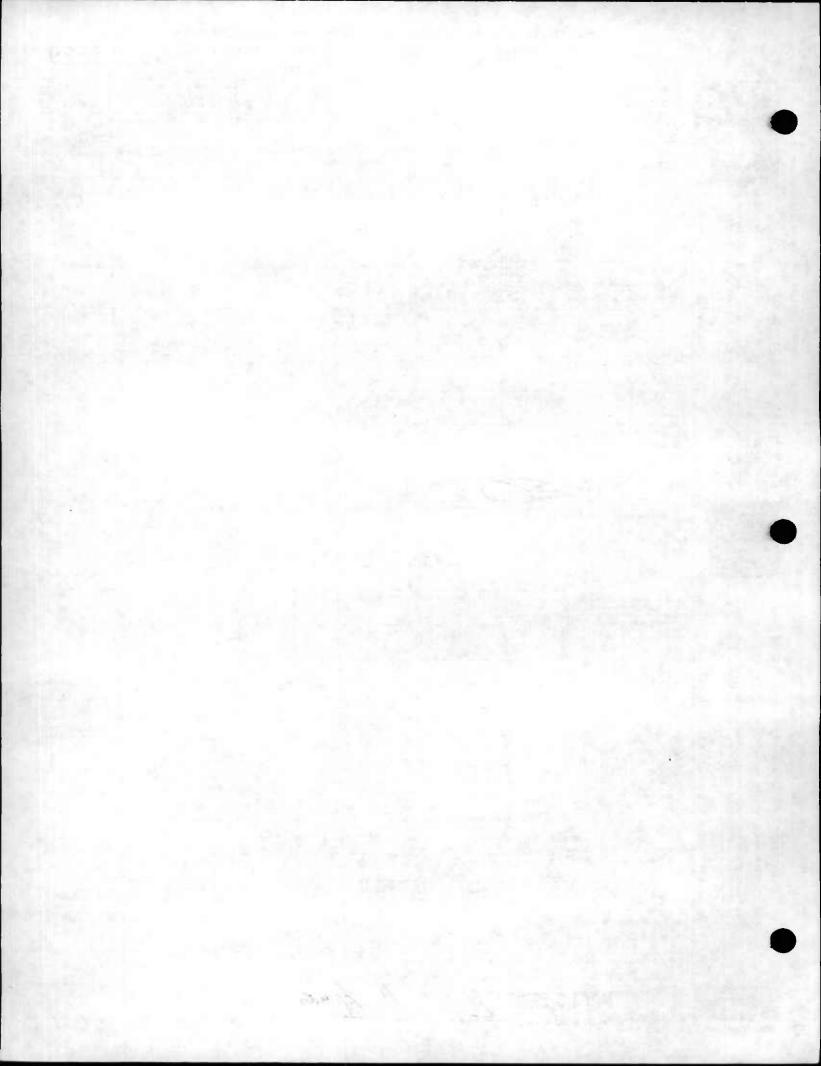
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State of Maryland / Department of Health and Mental Hygiene 0 15529

	Decedent's Name	(First Middle I as	at)		Ce	rtificat	e or	Death		2. Date of Dea	leg. No.		3. Time o	f Death
Physician	Robert S.	Band	,,,							Month	DOODDay	Year	3:25,	
/Medical Examiner	4a Facility Name (If r	ot institution, give	street and numb	er)				4b. City, To	wn, or L	ocation of Death		ty of Death		-
LAdimirei	Mariner Hea	1th of Lau	irel					Laure	1			Prin	ce Georg	ges
Funeral Director	5. Social Security Nur 215–12–8224		ex 7. ▼M 2□ F	Age (In yrs. 78		If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Da) April 29	1922	9. Birth	place (State of try)	or Foreig
	Usual Residence of D	ecedent 10b. County		10c City	y, Town or Lo	ocation							t0d. Inside C	ity Limit
Sa-f sho outlast a	MD	Pr	ince Georg		Laure1								1 🗆 Yes	
r tems 23s or 28s-fa niver must be notified Funeral Director	10e. Street and Numb 51 A Street					10f. Zip		20707			10g. Citizen of		ntry?	
	11. Merital Stetus 1 Never Married XX Widowed 4		12. Wes Decede Armed Force PXXYes 2 If Yes, Give Year or Date	□No		Was Dece If Yes, spe 1 Yes	cify Cubi	lispanic Origan, Mexican Specify:	gin? (Sr , Puerto	pecify Yes or No- Picen, etc.)		ace - Ameri ack, White, ify:		
tal Hygiene. John then "natural", of word, the Medical Exar. Be Completed by	(Specific	5. Decedent's Ed	ucetion de completed)		16a. Dece (Give	dent's Usu	al Occup	ation during most	of work	king	16b. Kind of I	Business/Ir	dustry	
mpie ne	Elementary/Second		College (1-4	or 5+)	1.30 (997)			during most			TM and a			
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and Mental H la marked out raumatic ever	Clifton B	and the same of						To. Wictine		ry Slunt		illo)		
t of Health and Mental Hygiene. If Item 27 Is marked other than or other traumatic event, the Me To Be Compi	19a. Informant's Nem Charles C		Type, Print) / Broth	er						rai Route Numbe	r, City or Town	n, State, Zi	p Code)	
Department of Health ar Important: If item 27 ia eny injury or other trau once.			Removal from Sta	ate C	lace of Disponentery, crei	metory or o	ther pla		13,	Date 2000	20c. Location			
Department of Important: If eny injury or once.	21. Signature of Fund	erel Service Licen	see Victor		, Jr. 2	2. Name ar Charle	nd Addre	ss of Facilit Steven	s Fu	neral Home , Baltimor	e, Inc.			
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s certificate hadirector, page	25. Was case referre	d to medicel						26. Place	of Dee	th (Check only o	ne)			
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n 24 hour ne Funera pletely fille edical (ysician: To the besi niner: On the besi and manne	s of examina										(s)
To the comp	29b. Signature and tit	1.	Allenor	49				se number 2580			29d. Date sign May 8,	2000	, Day, Year)	
	30. Name and address	s of person who		of death (Item					~~	710				
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Piease Type or Print in Biack Indelibie ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** Delma Mae May 2000 13, 6:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care at Cherrywood Reisterstown Baltimore If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) May 15, 1904 If Under 1 Year 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F Months Days 95 Yrs. 218-05-2735 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 ☐ No Maryland Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 512 Avenue Arsan 21225 238 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: natural, or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic evens 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer C. Mitchell Margaret M. Cooper 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Piper Road Reisterstown, MD 21136 Grace Virginia White/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 16, OGIen Burnie, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Libersed Esk ilwi 11824 Reisterstown Road Reisterstown, MD 21136 23a. Part1. Enter the sease of complications that caused the death. Both ont enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lanear unit only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Throm bosis Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Physician/Medical Examiner ettending physicien and for use as the bunal-trensit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to Completed 24a. Wes an autopsy performed? been : completion of cause of death? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) exeminer? Other: 4 Natising Home 5 Residence 6 Other (Specify) edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D15872

State Registrar

DHMH 16 Rev 6/95

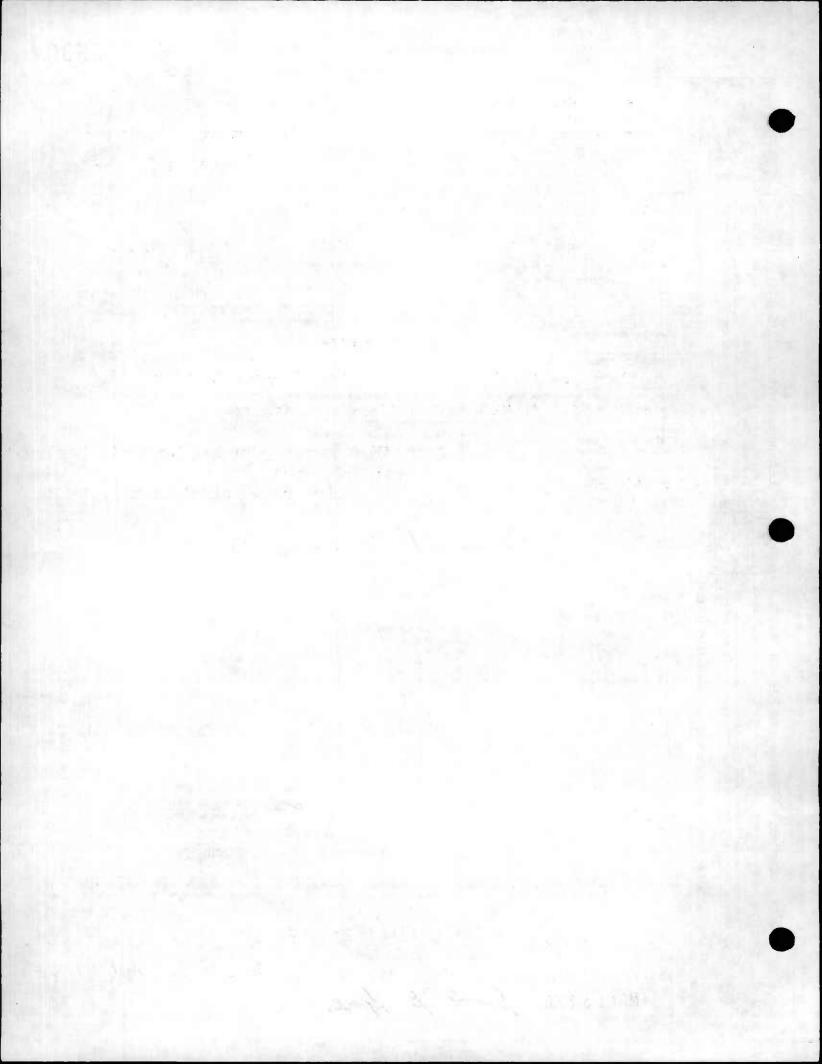
Reisdendour Md 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25 Main

32 Registrar's Signature

BOB



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State of Maryland / Department of Health and Mental Hygiene 0 0 | 553 |

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		10e. Street and Number 10f. Zip Code 2606 Maryland Avenue 21218										izen of Wha ited S					
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	21.	Signature of F	5 □Other			tin	Me		2. Name and Smith	d Addre		s Funera	al Ho	me, P	.A.	re, MD	
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4e Facility Neme (If not institution		imber)			4b.	City, Tov	wn, or Lr	ocation of Dea	ath	4c. County	of Deat	th
North Arund	del Hospit	al				Gler	a Bur	rnie		Ar	ine	Arundel
5. Social Security Number 217-07-1094	6. Sex 1 □ M 2 ☑ F	7. Aga (In yrs. 81.	last birthday) Yrs.	Months E		If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, D Sept.	Dav. Y	(ear)	9. Birti	thplace (State or Foreign ountry) ryland
Usual Residence of Decedent		100 0										
Maryland 10b. County	N/A		ty, Town or Local Baltimo:									10d. Inside City Limits PYPes 2□ No
10e. Street and Number				10f. Zip Co	ode				10g	. Citizen of W	Vhet Co	untry?
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19e. Informent's Name/Reletions	ship (Type, Print)		19b. Meilin	ig Address (5	Street an	d Numbe	or or Run	ral Route Num	iber, C	Lity or Town,	Steta, 2	Zip Code)
Judith A. Gibso	on (Daught	er)	2711	Cold S	atur	day	Dr.	Finksb	our	g, MD	210	48
20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S	3 □Removel trom	State 20b. P	Place of Dispos cematery, crem TO Cres	sition (Name natory or othe	of er place)		t	Dete /15/00	20	c. Location -	City or	
21. Signeture of Funeral Service	Licensee	Jana	() 22.	. Name and /	Addrass o	of Facility	MAmb 1	rose Fu g Road	une	ral Ho	me,	Inc.
23a. Pert1. Enter the diseese, or shock, or heert teilure. List	t only one cause on e	eech line.	_				cerdiac r	or respiratory	errest			Approximete Intervat Between Onset and Deeth
Immediate Cause (Final disaase or condition resulting in death)		EPTI										5DAYS
	. As	Due to (o			EU	MO	>N/	A				12 DAYS
Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events.)	с		or es a consequ									
thet initiated events resulting in death) Last	d	Due to (or	or es e consequ	Jence of):								
Part II. Other eignificant condition					_			23b. Die	d toba	ICCO USE COI	ntribute	to the cause of death?
CEREBRO								10] Yes	2 D No	3 □ Pr	robebly 4 Unknown
CONGES	TIVE H	EART	TH	AILI	URF	Ξ		24a. We per	es an e			Were eutopsy tindings evailable prior to completion of cause of death?
HYPOTH		DISM	1					10) Yes	2010		1 Yes 2 YNo
Wes case referred to medica	al la				-	26 Place	of Deat	th /Check only	(one)			

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tunneral director, page 2 should be detached for use as the buflat-transit

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner Sequentially list if eny, leading to causa. Enter Up Cause (Diseese that initiated eve resulting in deat

Physician

/Medical

Examiner

Director

To Be Completed by Funeral

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Heme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

25. Wes case re exeminar?

Hospitel: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 1 Neturel 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28c. Injury et Work? 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stele)

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

M. SHIRA 21, M.D. NORTH ARUNDEL

29c. License number 46962

HOSPITAL.

29d. Data signed (Month, Day, Year) MAY 13, 2000.

MD 21061.

State

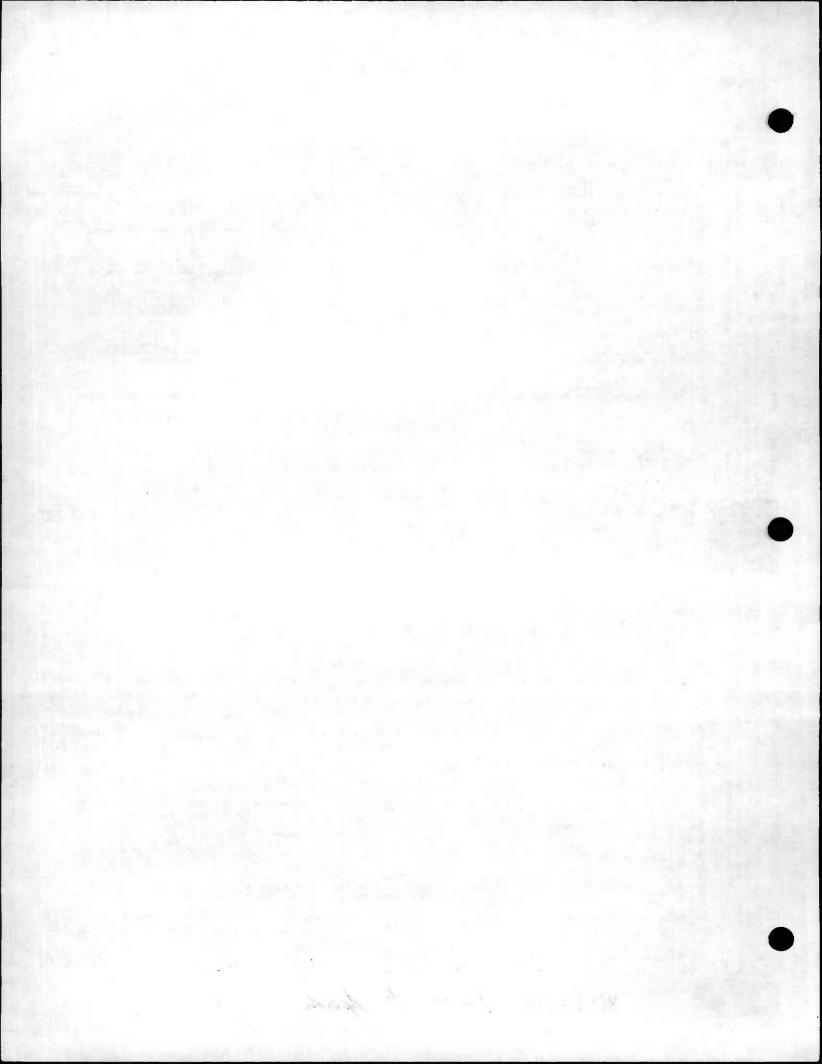
Medicai Certification: To

M. SHIRAZI, M.D. 31. Data filed (Month, Dey, Year)
NAY, 1 5 2000 Registrar

4 Homicide

32. Registrar's Signeture

oorks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Day Month **Physician** ISABELL JENKINS BELL May 10, 2000 /Medical 7:35 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Baltimore, Gilchrist Center Baltimore County Towson 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year Months Days 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Funeral 1□M 2\ F Director 220-46-8319 June 25, 1914 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore County Towson 10f. Zip Code 10g. Citizen of What Country? 8603 Drumwood Road 21286 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yas, Give Year or Detes: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be William E. Jenkins Elizabeth W. Sleeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Ms. Carole B. Dean 8603 Drumwood Road, Towson, Maryland 21286 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdns 5/13/00 Timonium, Maryland 21. Signature of Fungual Service Occasion

Martin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest,

Approximately 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest,

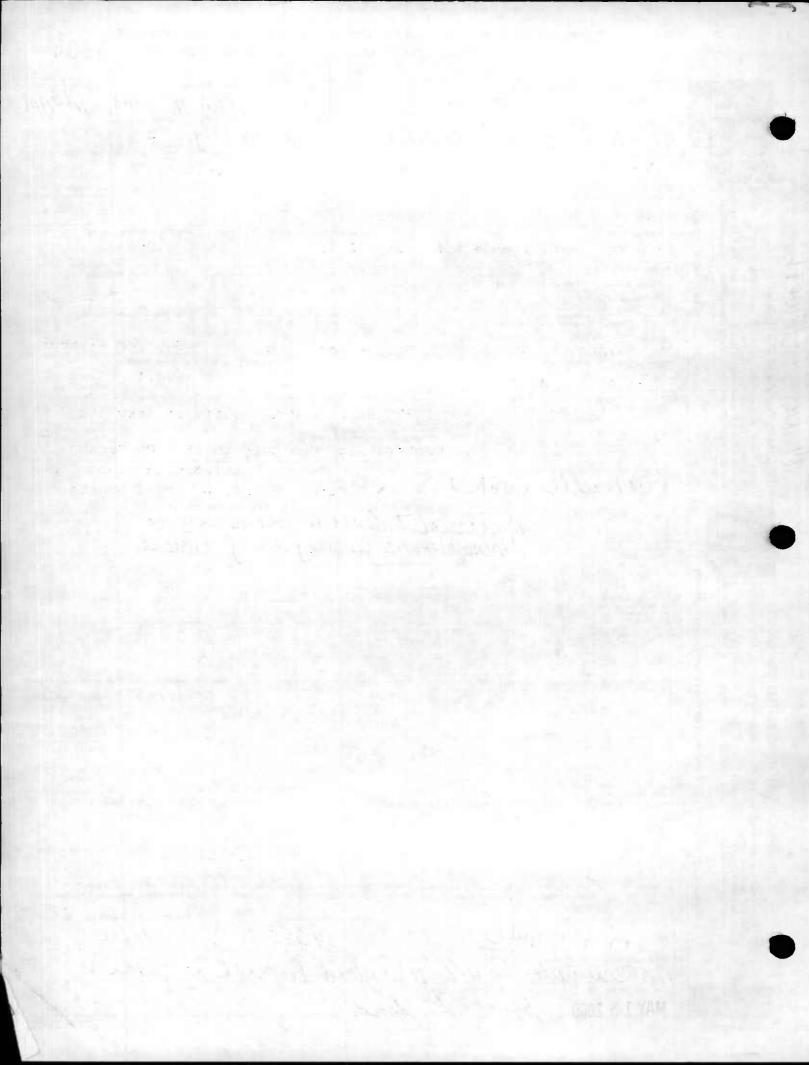
Approximately 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest,

Approximately 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, Approximata Interval Between Onset and Death **Physician** Immediata Cause (Final diseese or condition rasulting in death) /Medical Stage dementin ears Examiner Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the deeth certificete be exe P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown be del Records. þ 24b. Were autopsy tindings evailable prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: Be 25. Was casa raferred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 QOther (Specify) 40 Spice Medical Certification: To 1 Yes 2 No this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division After 1 Meturel 5 Pending s efter death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) in by 4 Homicide e Hospital or 24 hours eff e Funeral Di 29a. Certifier 🔀 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. within 2 To the \$ 29c. License number 29d. Date signed (Month, Day, Year) 0 2000 30. Name and addrass of person who complated cause of deets (Item 23a) (Type, Print)

11) D. D. Le. (-BMC/6701 N-Charles St. Bolts. Md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Darks Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 2000 **Physician** Charles Caldwell · /Medical 4b. City, Town, or Location of El 4c. County of Death 4a Fecility Nama (If not institution, giva street and number) Examiner Hmore land If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days XM 2□ F Months 87 218-09-2617 Director 02-16-13 SC Usuat Rasidenca of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County menso other than "naturel", or items 23s or 28s-f showed event, the Medical Exeminer must be notified at 1 Yes 2 No Director Baltimore NA 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1600 Mt. Royal Avenue Apt. 401 21217 USA Funeral 12. Was Dacadant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Spacify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Never Marriad 2 ☐ Married 1 Yas 2 No Spacify: Specify: à Black 3 X Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Chrysler Plymouth 3rd. Grade Master Technician 18. Mothar's Nama (First, Middla, Maidan Sumema) 17. Fathar's Nama (First, Middla, Last) Be 8 Caldwell Caldwell Pages 1 and 2 should 2 Charles Mary 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19e. Informant's Name/Reletionship (Type, Pnint) S. Jean Morgan 3220 Mayfair Road Baltimore, Maryland 21207 mportant: If item 27. 20b. Plece of Disposition (Nema of cematary, cramatory or other place) 20c. Location - City or Town, Stata MD. 20a Mathod of Disposition 1 ☑ Burial 2 ☐ Crametion 3 ☐ Removal from Stata Western Star Cemetery 05-16-2000 Catonsville, 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Approximata Intarval Batwaen Onsat and Daath 23a. Part I. Enter the disease, or complications that shock, or heart failure. List only one cause on used the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, secondary Infarction **Physician** /Medical Immediata Causa (Final ARYER disaasa or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last pue the buriel-tran Dua to (or as a consequence of) P.O. Box 68760. ettending physician Physician/Medical Dua to (or as e consequenca of) signed by the e Part II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uaa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, þ 24b. Were eutopsy findings aveilable prior to completion of causa of daath? 24a. Was an autopsy performed? Completed peeu page 2 1 ☐ Yas 2 ☐ No 1 ☐ Yas 200 No or Attending Physician: funeral director, 25. Wes casa referred to medical Be 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA After this 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Dascriba how Injury occurred 1 Natural 5 Pending death. 1 Yas 2 No invastigation efter death Director: / 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e 29a. Certifiar 1 Certifying Phystoten: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data end place, end due to the causa(s) and manner stated. To the Vithin 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licanse number ogen 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print) General Hospita m. D.40 anisha 31. Data filed (Month, Day, Year) 32. Ragistrar's Signetura State Registrar 2000 DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15535 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth CARRINGITON Month **Physician** ARENCE 2000 :27 AM 4c. County of Deeth /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TIMORE MANORDENE RD. 5. Social Security Number 213 · 30 + 5 3 7 Usual Residence of Decedent 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrş. last birthday) Days Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside/City Limits MA 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S Aumed Forces? 1 12 Yes 2 12 No 14 Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Merital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 20 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Mg. DO NOT; use refired). **Tended of the control of the c 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18/Mother's Name (First, Middle, Maiden Sumame) B 19e. Informent's Neme/R alienship (Type) Print) et and Number or Rural Route Number, City or Town, Stete, Zip Code) 4 MW, 402/2/ 20c Location - City or Town, State iPlace of Disposition (Namcemetery, cremetory or of thod of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1mu,402/21 mo 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth CONGRESTIVE HEART FAILURE Immediate Cause (Finel disease or condition resulting in death) Physician/Medical Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDEN 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? FIBRILLATION SEIZURE DISORDER 1 ☐ Yes 2 No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home Medical Certification: To 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Netural 5 Pending investigation 1 Yes 2 No

Box 68760, P.O. I Records, of Vitai

The lew requires that the death certificate be executed physician s the buriel certificate or Attanding Physician: this funeral (After

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Introprient: if from 27 is marked other than "natural", or forms 23s or 28s-f show any injury or other traumstic event, the Medical Examinar must be about

Physician

/Medical Examiner

Baitimore, Maryland 21215-0020

Division To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun

State Registrar

DHMH 16 Ray 6/95

29b. Signeture end title of certifier 30. Name and address of person who compl

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

MARYLAND

bedeath (Item 23a) (Type, Print)

BALTIMORE,

NORTH GREENE STREET

10 31. Dete filed (Month, Day, Year)

2 Accident

3 Suicide

29e. Cartifier (Check only one)

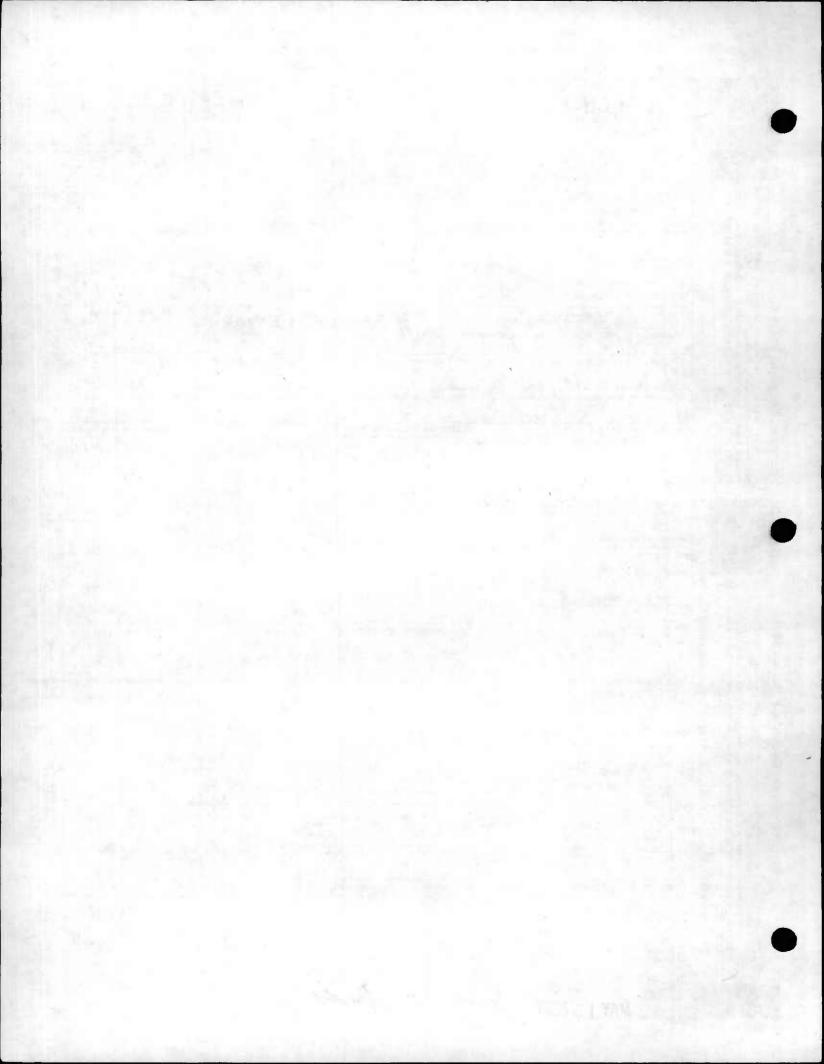
4 Homicide

MAY 1 5 2000

6 Could not be determined

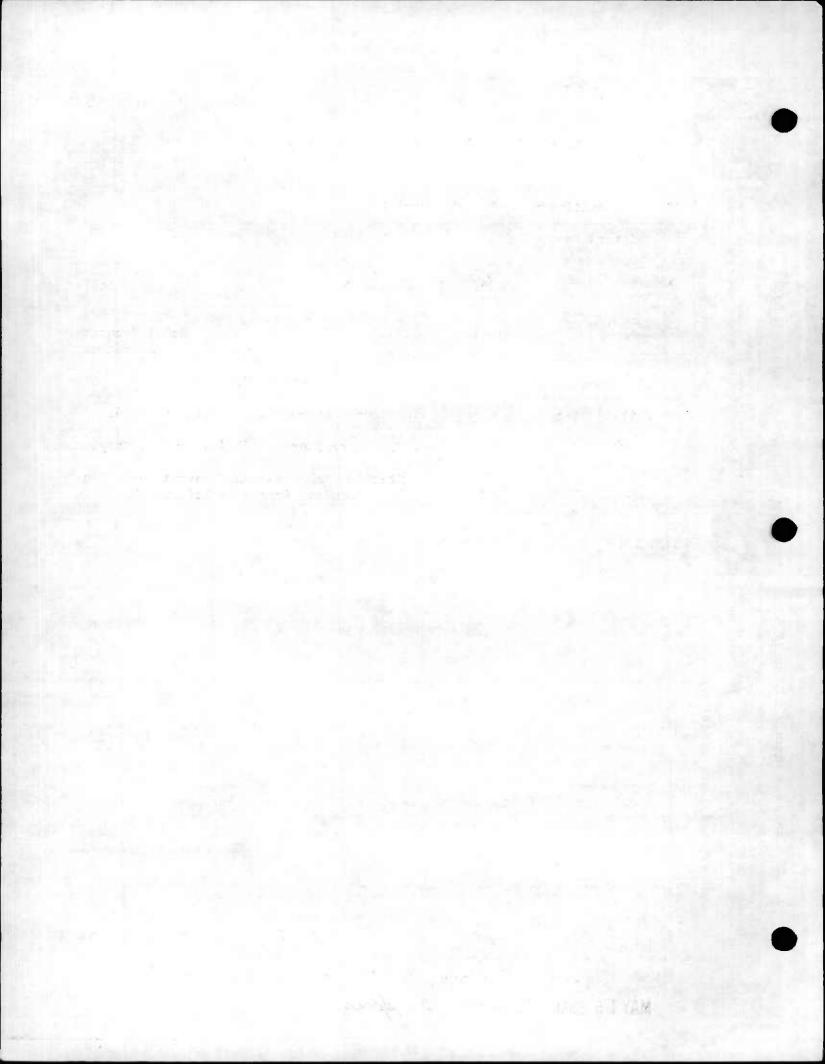
32. Registrar's Signature

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Cartificate of Dooth

2.00	Certificate of Death	Reg. No. 00 15536
Physician	Decedent's Name (First, Middle, Last) LaVerne R. Cunningham	2. Date of Death Month Month Day Year Year 5:to P.m
Medical kaminer neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	Location of Death 4c. County of Death White Day Prunde 8. Date of Birth 9. Birthplace (State or Foreign
ctor	215-07-0345 1 M 2 F 81 Yrs. Months Days Hours Min.	June 22, 1918 Maryland
rector	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 万No
Funeral Director	10e. Street and Number 801 Winters Lane 21228	10g. Citizen of What Country? USA
by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	pecify Yes or No- lo Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Control of NOT use retired)	king 16b. Kind of Business/Industry Social Security
Com	Elementary/Secondary (0-12) College (1-4or 5+) Secretary	Administration
Be	17. Father's Name (Pirst, Middle, Last)	ne (First, Middle, Maiden Surname)
2		Voe1ker ural Route Number, City or Town, State, Zip Code)
	Joan Childs- niece 110 Linwood Avenue G1	
any injury or curer traditioned availt, the page. To Be Compi	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State 5/14/00 Laure1, Maryland
should be detached for use as the burial-transit unit of the state of	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. Listophy one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Onset and Death
Phys	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Be Completed by Physician/N		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
S	25. Was case referred to medical 26. Place of Dec	1 Yes 2 No 1 Yes 2 No
on: To B	Hospital: /	ath (Check only one) forme 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
edical Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location (Street and Number or Rural Route Number, City or Town, State)
dicai C	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation.	, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
Me	29b. Signature and title of certifier WD 29c. License number D 43977	29d. Date signed (Month, Day, Year) May 1 2000
Chata	30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) Author Durium 301 Hrants Bear Glen Burbone . 31. Date filed (Month, Day, Year) 32. Registrars Signature	mp 21061
State Registrar	MAY 1 5 2000 Serve & Sparks	



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** May 2000 00mD /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Baltmore If Under 24 Hrs. 8. Date of Birth Barrew Medical Center Johns Hopkins 8. Date of Birth (Month, Dey, Year) Sept 30, 19 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months Devs 10M 20F Hours 217-74-8743 1905 MD Director 94 Usual Residence of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or flams 23a or 28a-f show the Mapical Examiner must be notified at 1 Yes 20 No Director MD Baltimore Dunda1k 10a Street and Number 10f. Zip Code 10g. Citizen of What Counfry? 231 Colcate Avenue 21222 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? 11 Marifel Status filed within 72 hours after ☐ Yes 2 XNo f Yes, Give 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 Widowed 4 □ Divorced Yeer or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fsther's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be Gustov Benser Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 a Depertment of Heelth or Important: if hem 27 is any injury or other trau Doris Sylvia- niece 2003 Codd Avenue, Dundalk, MD 21222 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - Cify or Town, State 1 Buriel 2 Cremetion 3 Removal from State Balto. Wash. Crematory 5/14/00 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Limited 22. Name and Address of Fecility Bradley-Ashton-Matthews Funeral Home, inc. 2134 Willow Spring Road, Dundalk MD 21222 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final umonia disease or condition resulting in death) Examiner Examiner DIP IDN attending physicien and for usa as the burial-transit The lew requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, by 24b. Ware autopsy findings eveilable prior to completion of ceuse of daath? 24e. Was an autopsy performed? Completed has 1 Yes 1 Yes After this cartificate To the Hospital or Attending Physician: within 24 hours siter death. To the Funeral Director: After this cartifica completely filled in by the funeral director, Be 25. Was cese referred to medical axaminer? 26. Placa of Death (Check only one) Othar: 4 Nursing Home 5 Residance 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Dete of tnjury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturet 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the basi of my knowledge, death occurred at the tima, data and place, and due to the ceusa(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the ceuse(s) end menner stated. 29a. Certifier

State Registrar **DHMH 16 Rev 6/95**

29b. Signeture and title of certifier

31. Date filed (Month, Dey, Year)

MAY 1 5 2000

Antonia

HONKINS

Bunco

sonns

32. Registrar's Signeture

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)



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LUNG DIAM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician** 10, 2000 IDA KUECHLE DRUMMOND Mav 11:00 A.M /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6110 Bellinham Ct. Apt. 621 Baltimore Baltimore 8. Dete of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 1 M 2 X F Director 212-09-8861 88 May 4, Usuel Residence of Decedent with the Manyland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pagas 1 and 2 should be filed within 72 hours after death with the Marylan nant of Haalth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be nothed. 1 ☐ Yes 2√ No **Funeral Directo** Maryland Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 6110 Bellinham Ct. Apt. 621 21210 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 NWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 years College (1-4or 5+) Chemical/ Electronics Executive Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Frederick Kuechle Katherine Mueller 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Katherine Widerman 8905 Garfield Drive Gaithersburg, Maryland 20882 (sister) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete permit. Pagas Department of H important: If ite any Injury or ot 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 5-13-200 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, of complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert teilure. List only one ceuse on each line. 6500 York Road Baltimore, Maryland 21212 Approximete Intervel Between Onset and Death Physician Myorardial Fragercho. /Medical Immediate Cause (Finel 404-5 disease or condition resulting in death) Examiner Examiner bunial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician a tha burial Box 68760. Physician/Medical Due to (or as a consequence of): 23b. Dfd tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 No Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Certification: 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After t completely filled in by the funera or Attending Neturel Z Accident 5 Pending investigation 1 Tyes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, sfreef, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Attenday mo 37016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenceh M. Green, m 6701 N. Charles St S. to 4105 Solthon, ~ 21204 31. Dete filed (Month Pay, Year) 32. Regisfrar's Signature State 2000 oaks Registrar

			ck lituelible lik. Assule		e.
Raymond McKenzie Edwards AMEND ITEMS: #23 PAR	Г I, 27,	State of Maryland / 28A-F PER MEO	Department of Health and Certificate of Death	Mental Hygiene	1553
1 Decedent's Name /Fin	et Middle Leet)			2 Date of Death	3 Time o

Physic /Medi	ian	nzie Edwards EMS: #23 PART 1. Decedent's Name (First Raymond	Middle, La	RAY	M. EDV	VARI		e or			2. Date of D Month May 0	Deeth Day		1255 pm
Exami	ner	4a Facility Nama (If not institution, give street and number) 805 Brooks Lane, Apartment #3					1		Balt	imore		N/		
Funeral Director		5. Social Security Number 218-46-904 Usuat Rasidanca of Deced		For the second s						24 Hrs. Min.	8. Data of B (Month, I	orth Dey, Year) .0-47	9. Bi	rthplece (Stete or Foreign country) NC
ahow	J.	10a. State 10b. 0					r Location							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the N	Director	10e. Street and Number	NA		Bal	tim	ore 10f. Zip	Code				10g. Citizar	of What C	XX
72 hours after deeth with the Maryland natural, or florms 23e or 28e-f show pical Examinar must be notified at	by Funeral Di	805 Brooks 11. Merital Stetus 1 Never Married 25 3 Widowed 4 Die	e Apt. 12. Was Deced Armed Ford 1 Yes X2 If Yes, Give Year or Dat	21217 S. 13. Was Decedant of Hispanic Of It Yes, specify Cuban, Mexical 1 ☐ Yes 2 🖫 No Specify			Hispanic Ori an, Mexicar	inic Origin? (Specify Yes or No- dexican, Puerlo Rican, etc.)			USA 14. Race - American Indian, Bleck, White, etc. Specify:Black			
d within giene. or then	Completed	15. Decedent's Er (Specify only highest grade) Elementary/Secondary (0-12) 11th Grade		fucation de completad) College (1-4 NA		(G lii	ecedent's Usu- ive kind of wo e. DO NOT u ull-T	rk dona se retire	na during most of working ired)			16b. Kind	of Busines:	
d 2 should be file th and Mental Hy 7 Is marked othe traumatic event	To Be		shin					18. Mother's Name (First, Middle, Maiden Katherine E				Edwards		
CENL	Ė	19a. Informant's Name/Re Marilyn A.												
bermit. Pages 1 ar Department of Hee mportant: If hem in Injury or othe		20a. Mathod of Disposition 1 □ Buriat 2 □ Crem 4 □ Donation 5 □ Of	nar (Specifi	y)	20b. Placa of Disposition (Name of commetery, crematory or other place) King Mem. Pk. Cemete							15-20	00 R	
Departition of the control of the co		21. Signeture of Funeral S	ervice Licer	A	1		22. Name ar					ore, l		land 21202 venue
Physician /Medical Examiner		23a. Part1. Enter the disas shock, or heart feilure tmmediate Cause (Finat disaase or condition rasulting in daath)	se, or com	one cause on aa	ARCOTIC				ng, such as	cardiac o	r respiratory	arrast,		Approximata tntarvat Batween Onset and Death
	ner	resoning in Geattry		Dua to (or as a consequence of):										
ata be axecuted nysician end he burial-trensit	Examiner	Sequentially list conditions if any, teading to immediat cause. Enter Undarlying Cause (Disaase or injury that injured to the control of the		D	Due to (or	as a con	sequence of):							
death certificata be ax e attending physician ed for use es the burial	Medical	that initiated events resulting in death) Last	1	Due to (or as e consequenca of):										
nat the d	y Physician/M	Part ti. Other significant co	enditions o	contributing to death but not resulting in the underlying cause given in Part I.							d tobacco ua		te to the cause of death Probably 4 Unknow	
requiras been sign should by	Completed by										24a. Wa	as en autopsy formed?	24b	. Wera eutopsy findings available prior to completion of causa of death?
- m d											1,2	Yes 2□I	No	Yes 2□ No
Physician: The this cartificate ral director, peg	o Be	25. Was case ratarred to mexaminer?	edical	Hospitat:				. Oti	her:		(Check only		10	
Attending Physical distributions of the funeral distribution of the funeral distributi	atlon: To		Pending	28e. Date of	Injury Dey Year)	28b. Tim	a of 2	8c. Inju Wo	4 LI NU	2	28d. Dascrib	sidenca 6 De how injury o		ecity)
atter des Directo	ertification:		Could not be letermined	5 = 2 - 00				, offica	011111101111				ROOKS LANE,	

29a. Certifier

Medical Certification: To Be Completed by 1 Natural 2 Accident

FOUND: HOME

UNKNOWN 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 805 BROOKS LANE, APT. 3, BALTIMORE CITY, MD, APT.

1 Certifying Physician: To the best of my knowledge, death occurred et the tima, date and place, and due to the cause(s) and mannar as stated.

**Complete: Continuous of the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and fitta of certifier

29c. Licansa number

O.C.M.E.

29d. Date signed (Month, Day, Year) May 04, 2000

30. Nema and address of person who complated causa of death (Item 23a) (Type, Print)

Stephen 5.
31. Date flied (Month, Day, Year)

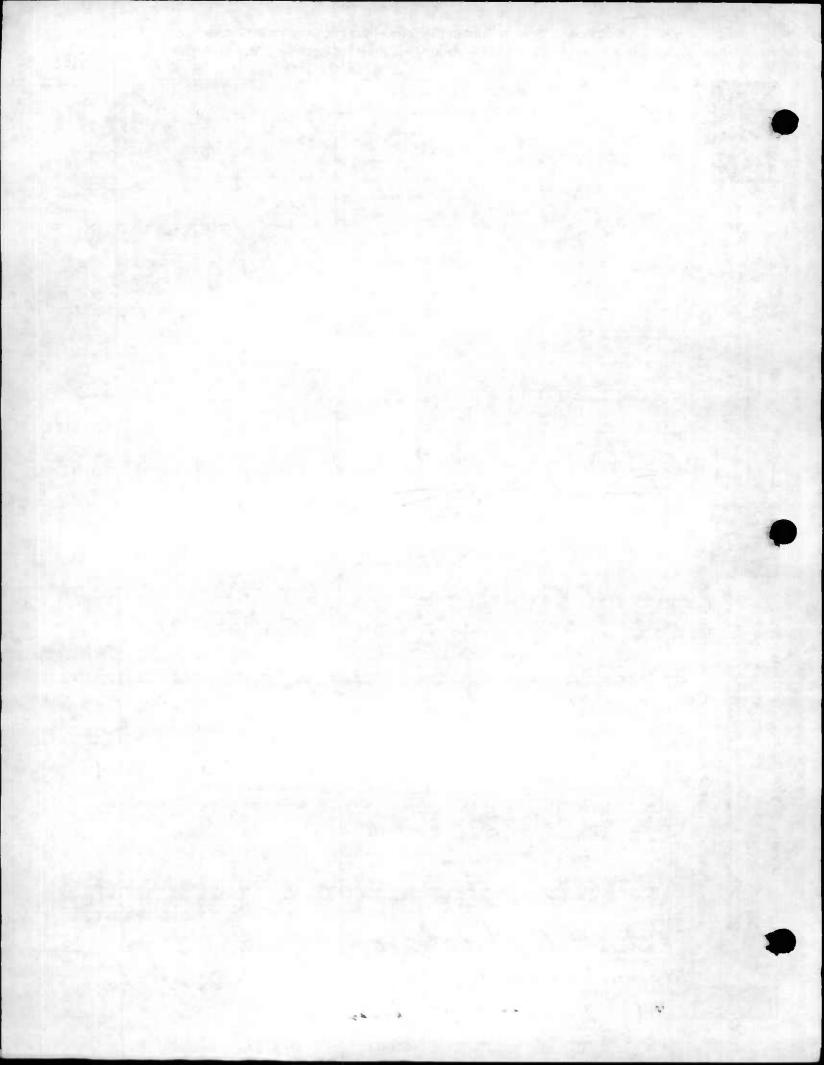
Radentz 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

within 24 hours after death. To the Funeral Director: A

To the Hospital or Attending Physician: The lew requires that the dea



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** MA FEGGINS RICHARD 2010 2012 /Medical 4c. County of Deeth 4e Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner JUHNS HOPKINS NA If Under 24 Hrs. 8. Dete of Bigth (Month, Day, 05-03-If Under 1 Year Months Devs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Hours XXM 2 F 58 Director 223-52-9656 Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23s or 28s-f show the Medical Examiner must be nothing at 1 ☐ Yes 2 ☐ No XX Funeral Director MD NA Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code filed within 72 hours efter deeth with 1504 N. Decker Avenue 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: "natural" Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shredded Paper Co. Paper Cutter 11th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked oth any Injury or other traumatic event Pages. Andrew Feggins Martha Valentine 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21213 19a. Informent's Neme/Reletionship (Type, Print) 1504 N. Decker Street Baltimore, Maryland Mary Feggins Baltimore, 20b. Plece of Disposition (Neme of cematary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State POBuriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 05-17-2000 Dundalk, MD 22. Nama and Addrass of Fecility 21. Signature of Funaral Sarvice Licensee Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical tmmediate Cause (Final disaase or condition resulting in death) Lung Cancer Examiner Due (or es a consequence of): Examiner to bacco USR The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or es a consequence of): Box 68760, ettending physicien for usa es the buria Physician/Medicai Dua to (or as a consequence of): P.0. Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1XYee 2□No 3□Probabiy 4□Unknown signed t Division of Vital Records, by cate has been significant page 2 should b 24b. Ware autopsy findings aveilebte prior to complation of causa of death? 24a. Was en autopsy performed? Completed After this certificate has 2 No 1 Yes 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 1 Yes 2 No eral Director: After this 28a. Dete of tnjury (Month, Day Year) inger of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No death. 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) end manner stated. Medical 29e. Certifier

Registrar

State

29b. Signature and titla of certifian

Y 1 5 2000

John

DHMH 16 Rev 6/95

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North Caroline St.

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32. Registrar's Signetura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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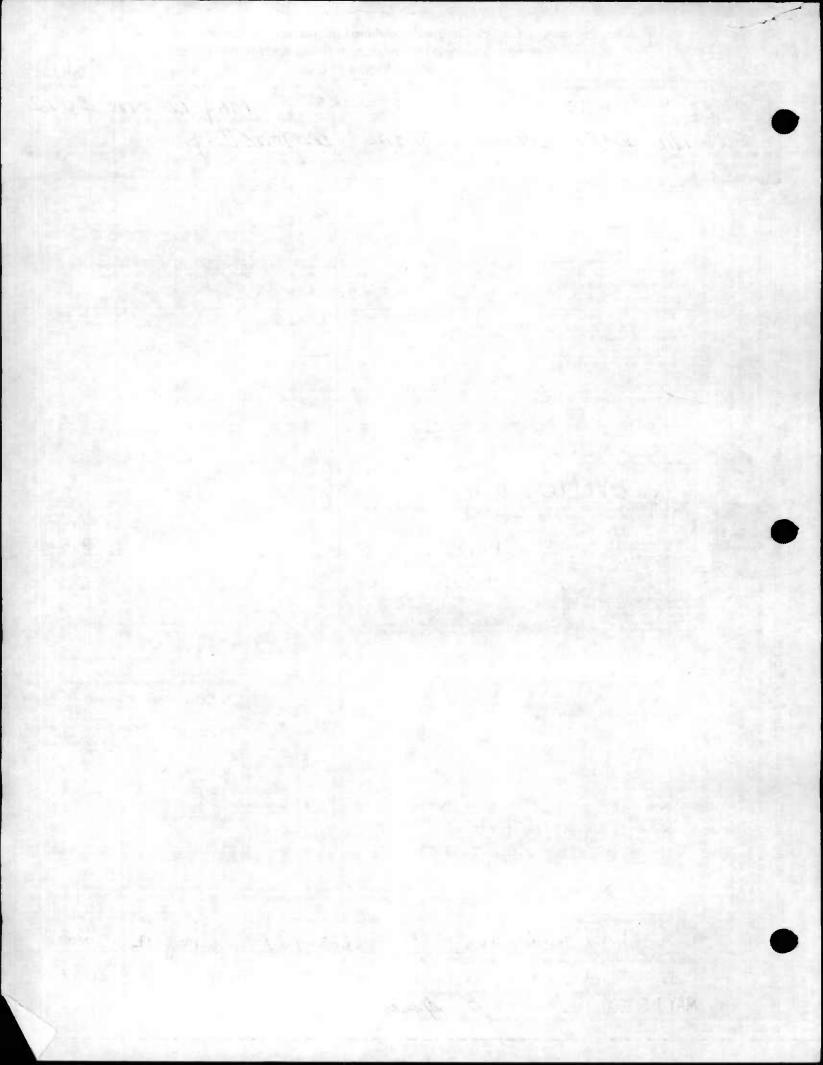
29c. Licansa number

RES-OOD

JHOC-7, Baltimore, MD

29d. Date signed (Month, Dey, Year)

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 12 - 2000 12:10 PM 05 SARAH W. FREDERICK /Medical 4a Facility Name (Il not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8. Date of Birth (Month, Day, Year) The Wesley Home N/A 9. Birthplaca (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2\ F Yrs. Director 239-20-8110 84 Apr 12, 1916 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Director Maryland N/A ,Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23a 4300 North Charles Street 21218 LISA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Frederich, Elementary/Secondary (0-12) College (1-4or 5+) Elementary Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and 2 should be saith and Mental James Clifford Westmoreland Bessie Alexander parmit. Pages 1 and 2 a. Department of Health and Important: If Illem 27 is ma any Injury or other to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George C. Frederick (Husband) nd) 4300 North Charles Street 100 Baltimore MD 200. Place of Disposition (Name of cemetery, crematory or other place) Saltimore. 20a. Method of Disposition 1 Burlal 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 5/16/2000 Baltimore, MD 21. Signatory of Funeral Service Licensee 22. Name and Address of Facility Martin D. Mitchell-Wiedefeld Funeral Home, Inc. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 48 luca. ASPIRATION PNEUMONIA Examiner Due to (or as a consequence of): Physician/Medical Examiner ALZHEIMER'S DISEASE END STAGE lew requires that the death certificate be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No à 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? ...capital or Attending Physician: Th. vin 24 hours after death. Ne Funeral Director: After this visitely filled in by the control of the co 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signefure end fitte of certifies 29c. License number 29d. Date signed (Month, Day, Year) 12, 2000 Culturary MD D16619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar C.VERGARA - SOARES

31. Date filed (Month, Day, Year)

MAY 15

2000

2211 WEST ROGERS AVE.

32. Registrar's Signature

BALTIMORE MD. 21209



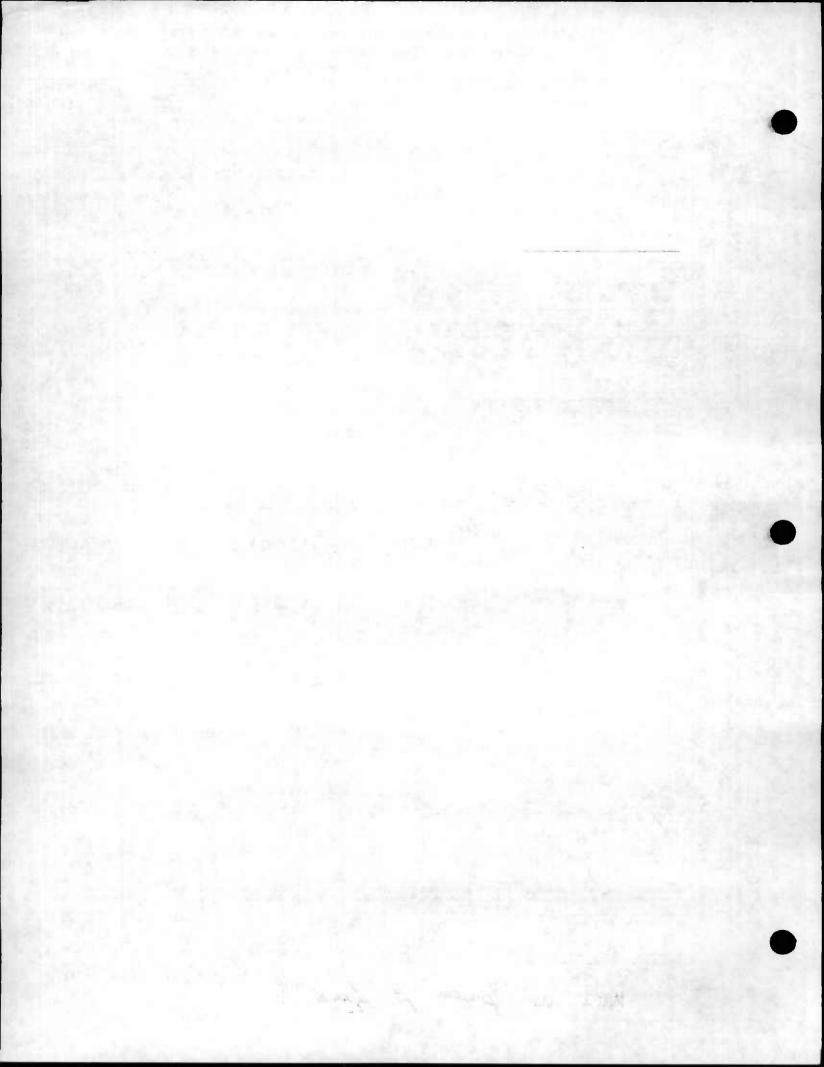
Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5542 AMENDED ITEM #10e PER FH G783 5/15/2000 AH Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Death MAY 11, **Physician** ANNE FINKELSTEIN 2000 12:20 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner JEWISH CONVALESCENT HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) AUG. 10,1913 Birthplece (Stete or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 ☐ M 2X F 215-05-0206 86 Director Usual Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "naturel", or itema 23e or 28e-f show rent, the Medical Examiner must be notified at 1 Yes 2 □ No Director N/A BALTIMORE 10e. Street and Number 2903 TERRY DRIVE #E 10g. Citizen of What Country? 10f. Zip Code 2903 TERRY DRIVE #2 21209 U.S.A. Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify p Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY EDUCATION 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Heeith end Mentel 27 le marked o r traumatic eve **ABRAHAM** ABRAMOWITZ MINNIE **JACOBSON** 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heeith or Important: If Item 27 is eny injury or other trauding. KARL FINKELSTEIN / HUSBAND 2903 TERRY DRIVE #E - BALTIMORE, MD 21209 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 X Burlel 2 ☐ Cremation 3 ☐ Removel from State BETH TFILOH CEMETERY 5/12/00 WOODLAWN, MD 4 Donetige 5 Other (Specify) neral Service Licent 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Ma Approximete Intervel Between Onset end Death at caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, **Physician** MMEDIATE /Medical Immediate Cause (Final disease or condition resulting in deeth) Examine Due to (or es a consequence of Examine physician and the bunal-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) 68760 Physician/Medical Due to (or as e consequence of) Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Uhknown þ Records. 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of deeth? hes page 219 No 1 Yas 1 ☐ Yes 2 ☐ No certificate of Vital il or Attending Physician; after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Yes edical Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, and dua to the cause(s) end menner stated. 29e. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certific 29c. License number

Registrar

State

30. Name and address of person who completed cause of deeth (Item 23a) (Type, P/nt)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle_Last) 2. Dete of Death 3. Time of Deeth Month 9:16PM Helen oebel 2000 May 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore ESS if Under 24 Hrs. enter If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth 9. Birthplece (State or Foreign County) MARYLAND 21828643 1 M 201 Months Deys Hours Min 68 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE ROSEDALE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8439 COCO ROAD 21237 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Maritel Stetus 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) OFFICE MANAGER CHARTTY 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) LOUIS HNYLA LOUISE HITRICH 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LEROY A. GOEBEL / HUSBAND 8439 COCO ROAD BALTIMORE, MD 21237 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State GLEN HAVEN 4 ☐ Donetion 5 ☐ Other (Specify) 5/17/00 GLEN BURNIE. MD 21. Signature of Funerel Service Upense 22 Name and Address of Feeling FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237 23e. Part. Emer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Metastatic Breast Concer Immediate Cause (Final disease or condition resulting in deeth) un-known Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? lower externi 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

Examiner use es the buriel-transit ettending physician. P.O. Box 68760, Physician/Medical Records, þ Completed page 2 s certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

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pemit. Pages 1 end 2 should be filed within 72 hours effer death with the Marylan Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes cese referred to medical exeminer? 1 Yes 2 No 27. Menner of Death 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, streel, fectory, office building, etc. (Specify) 4 Homicide

**Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

MD

31. Dete filed (Mon

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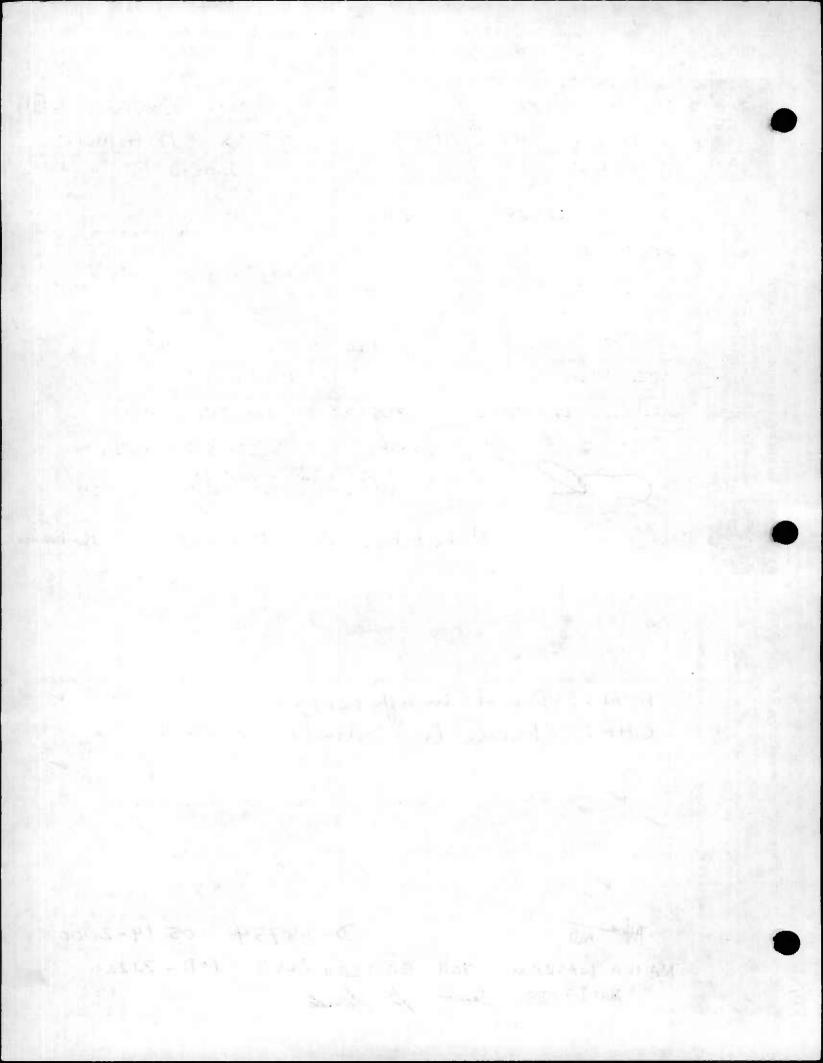
30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

I 5 2000

WASEBM.

BASTERN BLUD - M.D - 2/221. 709.

State Registrar 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death MAY 14, **Physician** MARY FLORENCE HARDESTY 2000 12:48 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner KNOLLWOOD MANOR GENESIS ELDERCARE MILLERSVILLE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, APRIL 2 year) 9. Birthplaca (Stata or Foraign Country), 1910 WEST VIRGINIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 90 Yrs Director 234-60-2642 Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f sho aminer must be notified at MARYLAND ANNE ARUNDEL GLEN BURNIE 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 THELMA AVE. 21061 UNITED STATES death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No if Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or item any Injury or other traumatic event, the Medical Experiment 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify Specify: WHITE þ 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working
 Ifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) DAVID AMBROSE DIXON HANNAH HOUSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) DORIS E. DRENNING / DAUGHTER 301 THELMA AVE., GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State METRO CREMATORY, INC. 2000 4 □ Donation 5 □ Other (Specify) CATONSVILLE, MARYLAND 22 Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. e of Funeral Service Licenses 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical Examiner Examiner sicien and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last P.O. Box 68760. Physician/Medical the Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Vilo 3 Probably 4 Unknown Records, Be Completed by ate has been signi pege 2 should be 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? ↑ ☐ Yes 2 25 NO 1 Yes 25 No certificate Division of Vital or Attending Physician: 25. Was casa refarred to medical director 26. Place of Death (Check only ona) axaminar? Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funaral 27. Manner of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after deeth. investigation 2 Accident filled in by the 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier Medical 11 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated. completaly (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Sig 29c. License number 29d. Data signed (Month, Day, Year)

Registrar

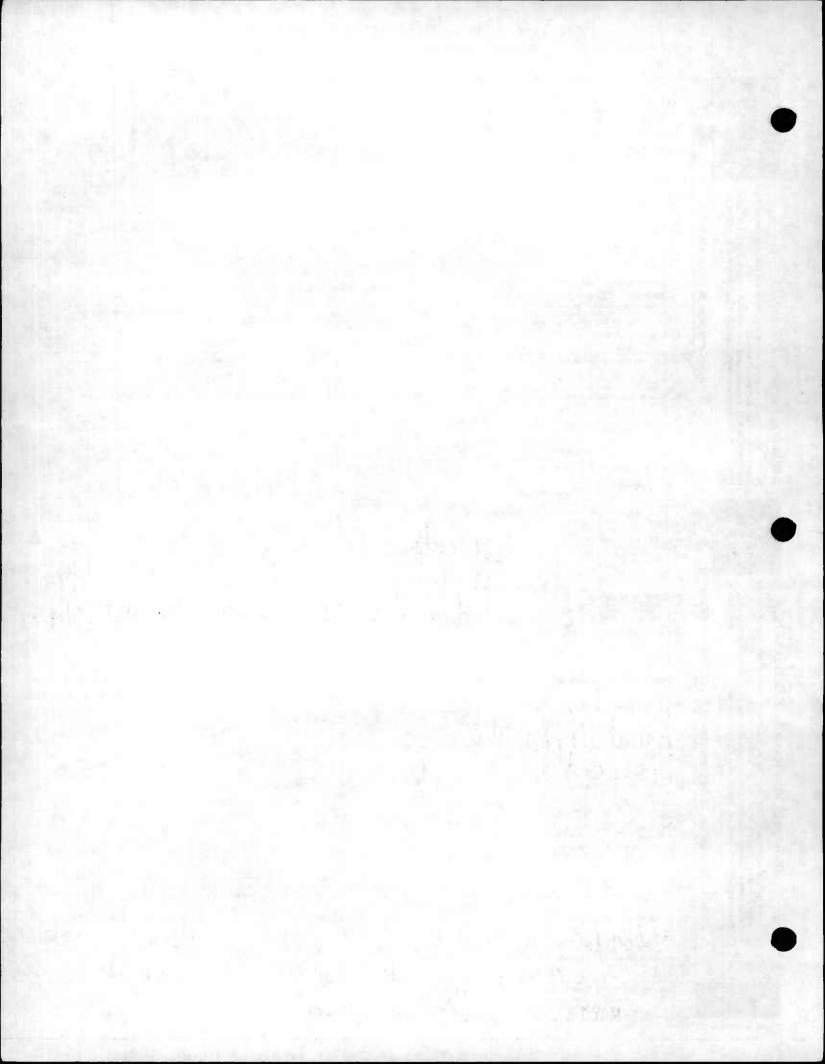
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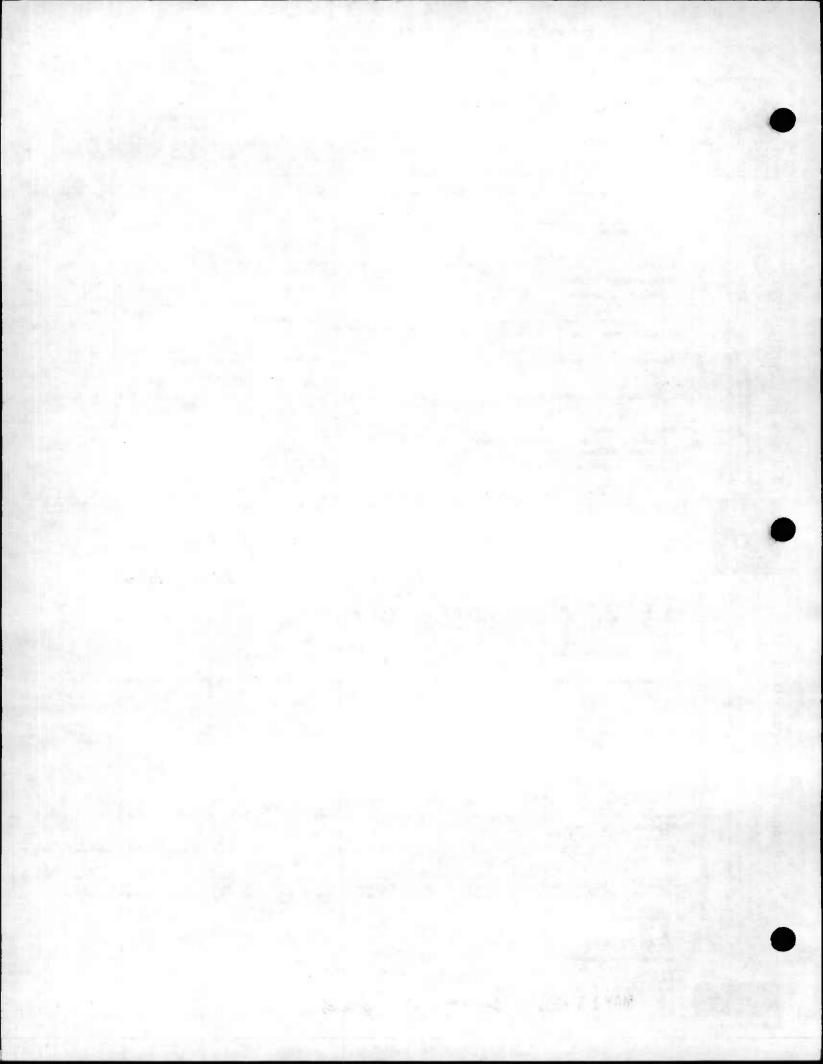
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Registrar's Sig



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_	0 0 0	10	Part It. Other signif	icant conditio	ns contributing to	death but not re	sulting In the un	derlying ceuse giv	ven in Part I.	23b. Did	tobacco use contrib	oute to the gause of death?
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o uc	Ing Ph After th Tuneral		27. Manner of Deat 1 Watural	5 Pendin	g (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injur		28d. Describe	how injury occurred	
Division	To the Hospital or Attending Ph Within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide	investig 6 Could r determ	not be 28e. Plac	ce of Injury - At ding, etc. (Spec	home, farm, stre sify)	eel, factory, office	Yes 2 □ No		(Street and Number o wn, Stata)	r Rural Routa Number,
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18327 5/12/2000	dical C	(Check only 2 Medical Examiner: On the besis of examination and/or investigation, in n	ne time, date and place, and due to my opinion, death occurred at the t	the cause(s) and ma time, date and place, (nner as stated. and due to the cause(s)		
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30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Moges Gebremanam 4660 Wilkens Ave Balto md 21229		& by / lelieno DI	P277	5/12/	2000		
moges Gebremarian 4660 Wilkens Au Belto md 21229							
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Registrar

State

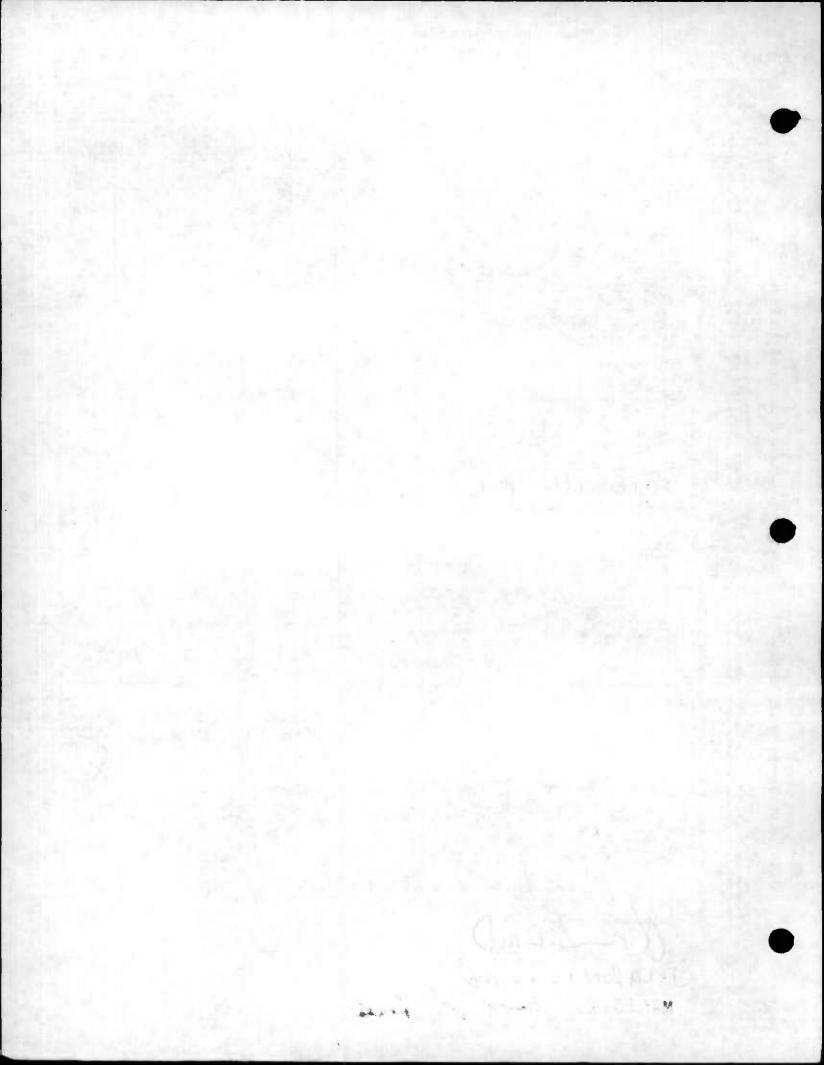
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32. Registrar's Signature

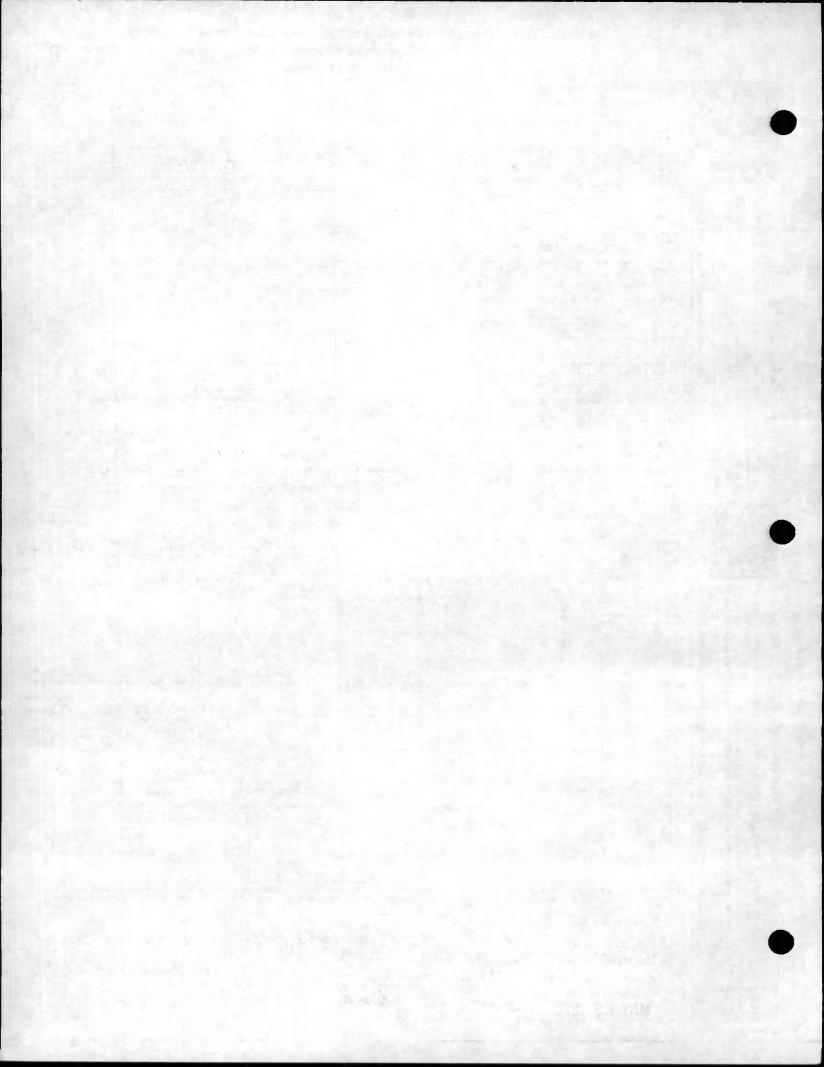
111 Penn Street, Baltimore, Maryland 21201



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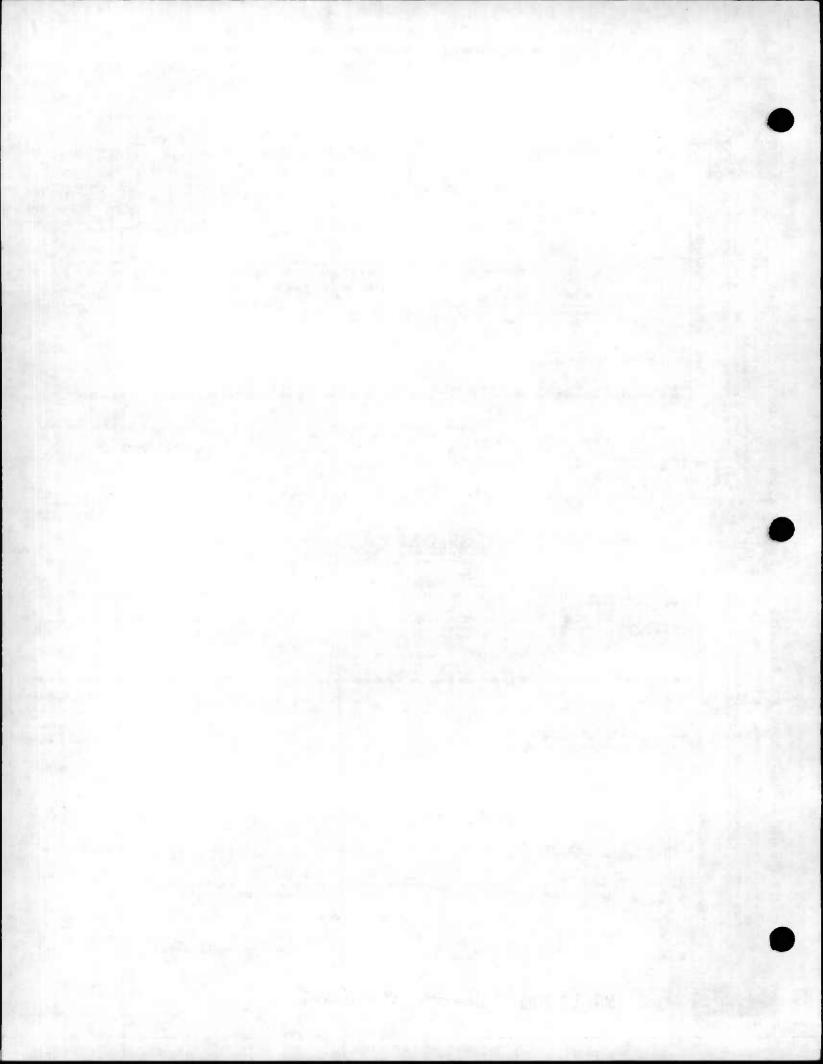
State of Maryland / Department of Health and Mental Hygiene 15548 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month Yaar **Physician** Edna G. Janyska 5:300.4 may 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number)
St. Elizabeth's Home 4c. County of Death Examiner Baltimore N/A If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Dec. 23 1896 Birthplaca (State or Foreign Country) **Funeral** Days 1□M 2X F Months Hours 212-07-5350 103 Yrs. Dec. Maryland Director Usual Rasidance of Decedant 10d. Insida City Limits 10c City Town or Location 10a Stata 10h Counts 1 Yas 2 No MD Baltimore Catonsville Directo 280-7 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda ŏ 572 Edmondson Avenue 21228 USA 23 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. "natural", or items 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 No If Yes, Giva 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 No Specify: altimore, Maryland 21215-0020 Specify: White à 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usuel Occupation
(Giva kind of work dona during most of working
lifta. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) the co Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be I nent of Health and Mental ant: If Hem 27 is marked of Emil Gunther Sophie Schaeffer 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 55 Pigeon Road Willimantic, CT 06226 t9a. Informant's Name/Raiationship (Type, Print) important: if hem 27 is a Kathy Hemenway/ granddaughter 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata camatary, cramatory or other placa) 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 DOthar (Specify) New Cathedral Cemetery 5/16/00 Baltimore, MD 21. Signature of Funeral Service Leafile Sterringdashton-Schwab Funeral Home Inc. 736 Edmondson Avenue BAltimore, MD 21228 23a. Part1. Enter the disease or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Daath **Physician** atheronderote cardio vandlar diserce royears /Medical Immedieta Causa (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examir Sequantially list conditions, if any, leeding to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): vong physician ise as the buria Dua to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown ğ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed **D800 2** 1 Yas 2 No 1 Yaa 2 No Division of Vital 89 25. Was case rafarred to medical 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of Certification: 5 Panding investigation 1_Natural 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicida #Pin 8 To the Hospital within 24 hours a To the Funeral C edical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifiar 29c. License number 29d. Data signed (Month, Day, Year) 00052746 may, 12 2000 ula 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)
Yelena lipnik 720 mai den Choice Lane beltinore MO21228 31. Data filed (Month, Day, Year) 32. Registrar's Signature, State MAY 1 5 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Nama (First, Middle, Last)	Reg. No. 2. Data of Death	3. Time of Death					
Physicia	Anna Wargarer Kalirman	May 12, 2000	7:05 pm					
/Medica Examine	the City Town on the Ci	Location of Death 4c. County	_					
Examine	3603 Longridge Court Abing							
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign					
Funeral Director	218 09 0555 1 M 2X F 81 Yrs. Months Days Hours Min	March 11,1919	Country)					
show Mall	10a. Stata 10b. County 10c. City, Town or Location		10d. tnside City Limits					
Mary 4.8h	Maryland Baltimore Essex		1 Yas 2 No					
the Me	10e. Street and Number 10f. Zip Code	10g. Citizen of W						
A S S S S S S S S S S S S S S S S S S S	107 Hampshire Road 21221	USA						
ns 2	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (- American Indian,					
T 2 0 5	Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 21221	rto Rican, atc.) Black Specify:	k, Whita, atc. White					
72 hours	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Bu						
	(Specify only highest grade completed) (Give kind of work done during most of work done during m	orking						
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ould be fill Mental H mrked off	John Quinn	nn Quinn Homan						
E DEE	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Jural Route Number, City or Town.	State. Zip Code)					
d 2 and 2 an	Carolyn Geckle (daughter) 3603 Longridge Court							
of Haalth Kem 27 I	20a. Mathod of Disposition 20b. Place of Disposition (Name of	Data 20c. Location -	City or Town, Stata					
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the the second	A		re county, Ma					
permit. Peges Department of Important: If It eny Injury or phes.	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral	al Home PA						
20200	1407 Old Eastern in	Avenue Essex, Ma	ryland 21221					
	234 Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardie book, or heart teilure. List only one cause on each line.	ac or raspiratory arrest,	Approximate Interval Between					
Physician	The state of the s		Onset and Death					
/Medical	Immediata Causa (Final disaasa or condition CARIDIAE ARREST							
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iden: The law requiras that the death cert certificate has been signed by the attending rector, page 2 should be detached for use.	Incusional hernia	O.L. William	24b. Were autopsy tindings					
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tal or Attending P rs aftar death. el Director: After t led in by the funera	building, atc. (Specify)							
splta nours	29a. Cartifiar 11 Certifying Phyetotan: To tha best of my knowledge, death occurred at the time, date end place	e, and due to the cause(s) and ma	nner as stated.					
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has complately filled in by the funeral director, page 2	(Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurrence and manner stated.	urred at the tima, date and place, a	and dua to the cause(s)					
outh ompl	29h Signature and title of cartifier 29c. License number	29d. Data signed	(Month, Day, Year)					
F S F 8	Saba Siddigs physician 84/496							
0		5-15	-00					
	30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print)	22 2 2 2 2 2	,					
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 405 STEMMERS RUN ROAD BALTO 31. Data tiled (Month, Day, Year) MAY 1 5 2000 32. Registrar's Signatura Apacts	mu 2/22	/					
01-1-	31. Data tiled (Month, Day, Year) 32. Registrar's Signatura							
State Registrar	MAY 15 2000 \ Mener LI Morales							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Day 48 2000 Ra lity Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 10. versity Longe If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) If Under Months Social Security Number Birthpleca (Steta or Foraign Country) 6. Sax 7. Aga (In yrs. last birthday) Days 10 M 20 F 46 Irav 21 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Lotherville Baltimore Maryland 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? USA 10 Spring knoll 21093 Court 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedent Ever In U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritat Status 1 Never Merried 2 Married 2 No 1 □ Yas 2 No Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Beaut Skin Care Anal. 2 years 18. Memar's Nama (First, Middla, Maidan Sumeme) 17. Fathar's Nama (First, Middle, Last) Shokat Abrahim 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) Hassan Kafshi husband Ct. Lutherville 10 Spring knoll MD 21093 20b. Place of Disposition Nama of cematary, crametory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date May 12 1 Burial 2 Cramation 3 Ramoval from Stata Aulaney Valley Memorial Gons 4 ☐ Donation 5 ☐ Othar (Specify) limonium 2000 Marylana 22. Jama and Address of Fecility Sarvice Licapsae of Dulance Valley, P. A. Brian T. Chishola Funeral Services 21893 200 E. Padonie Rd. Timoniva Past. Enter the disease, or complications that causad tha daath. Do not anter tha moda of dying, such as cardiac or raspiratory errest, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Causa (Finat Semia disaasa or condition rasulting in death) Due to (or as a consequence of); 5 eps 6 H037 Dua to (or as e consequence of): Dua to (or as e consequance of):

Physician /Medical **Examiner**

and

attending physician the

been signed by the should be detached

After this certificate has

eral Director: After thi filled in by the funeral

Scripletely

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Certification: To

Medical

Physician:

Attending Division

or A after

To the Hospital within 24 hours a

50

The law requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records,

Physician

/Medical

Examiner

10a. Stata

Funeral

Director

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or items 23a or 28a-f

"netural"

Department of Health and Mental Hygiena. Important If Item 27 is marked other than

traumatic

event, the Medical Examiner must be notified at

Funeral Director

Completed by

Be

with the Meryland

Pages 1 and 2 should be filed within 72 hours after death

Maryland 21215-0020

Saltimore,

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Disease or trijury that initiated evants rasulting in death) Last by Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Inpatiant

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Was an autopsy parformed? 1 Yas

24b. Were eutopsy findings evallable prior to complation of cause of daath? 1 Yas 2 No

26. Piace of Deeth (Check only one)

Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Dascribe how injury occurred

28a. Dete of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 1 TYas 2 No 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mennar es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier

5 Pending investigation

6 Could not be

25. Was casa referred to medical axaminar?

1 Yas 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

29c. Licansa number

29d. Date signed (Month, Day, Year) ,2000

30. Nama and addrass of person who complated cause of death (Itam 23a), (Type, Print)

Tur South GREENE Loha

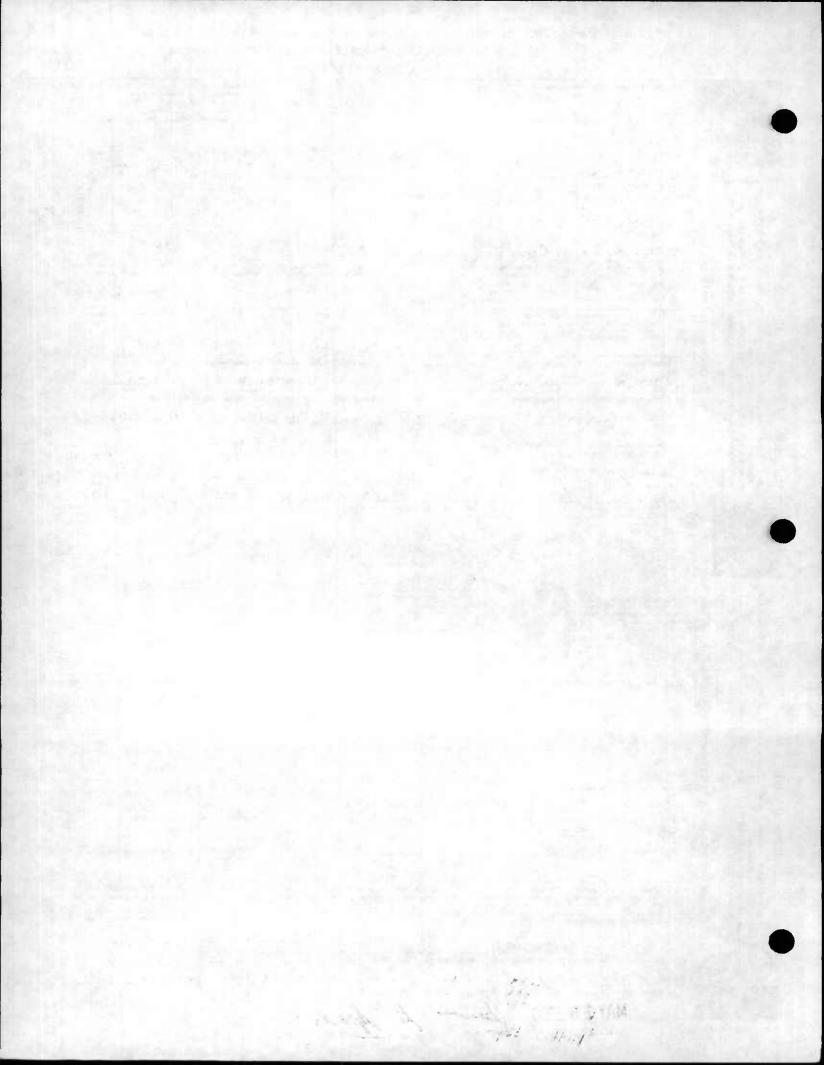
31. Data filed (Month, Dey, Year) 32. Registrar's Signatura

2000 15

2 ER/Outpatiant 3 DOA

ORIGINAL

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 555 Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Thomas P. Kidney 12, MAY 2000 10:15 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 6, 1930 Birthplace (State or Foreign Country)
 MA **Funeral** Days 1₩ 2□ F Months Hours 025-20-8932 69 Yrs. Director Usual Residence of Decedant 10a State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Maryla MD Prince Georges Andrews Air Force Base 1 ☐ Yes 2 No Director must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2130 Brooks Drive, Apt.-302 20747 United States Funeral 12. Was Decedent Ever in U.S. 1
Armed Forcas?

ADD Yes 2 No Air Force
If Yes, Giva
Yaar or Dates: 1951–1957 Race - American Indian, Black, White, atc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after b Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) US Air Force Staff Sergeant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Kidney Thomas Delia O'Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2130 Brooks Drive, Apt. -302 Andrews Air Force Base
Maryland 20747
of Disposition (Nama of Data 200. Location - City of Town, State Kay Kidney Wife If them 27 h 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Saint Mary's Cemetery May 17, 2000 Department of Important: If MA Lynn, 4 ☐ Donation 5 ☐ Other (Specify) To Fungral Service Licensee Victor P. Doda, Jr. 22. Nama and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on and the cause of the death. Approximate Intarvai Between Onset and Death **Physician** Immediate Causa (Final disease or condition rasulting in death) /Medical METASTATIC COLON CANCER UNKNOWN Examiner Due to (or as a consequence of): Physician/Medical Examiner PULMONARY EMBOLISM UNKNOWN The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Be Completed certificate hes page 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medicai Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation after deeth. 1 ☐ Yes 2 ☐ No 2 Accidant the 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicida within 24 hours a Hospital 29a Certifier 15 Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. Licansa numbar 29d. Date signed (Month, Day, Year) 29b. Signature and title of confirm

DHMH 16 Rev 6/95

Registrar

31. Data filed (Month, Day, Year) MAY 1 5 2000

THOMAS

G. FRASER, MAJ, USAF, MC 32. Registrar's Signatura

MO

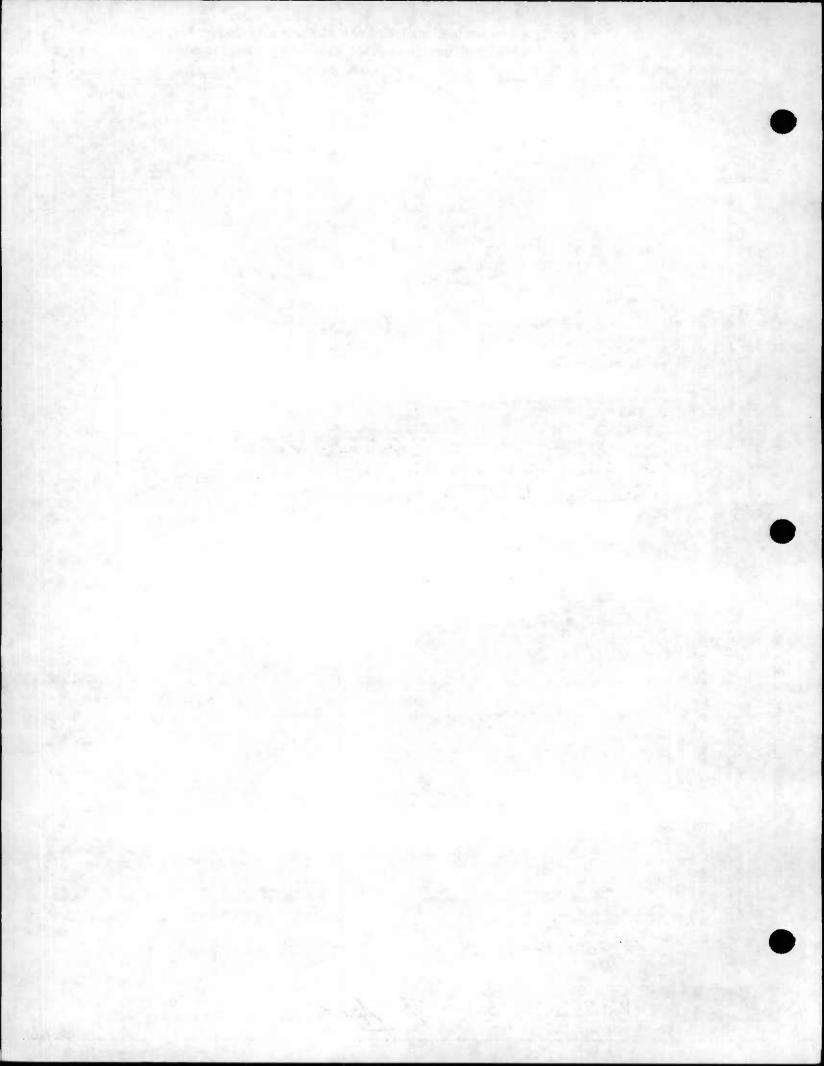
ANDREWS AIR FORCE BASE, MD 20762-6600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 89 MDG/1050 W PERIMETER RD

ORIGINAL

OH 35-07-0341-F

MAY 13, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 2000 Dorothy Lee 6:15 PM 4e Facility Nama (If not institution, giva street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth Month, Day, Year) 02-01-09 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 1□ M 2□ F Days 215-34-0371 91 Yrs MD Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Harford Phoenix 1 ☐ Yas 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13702 Jarrettsville Pike 21131 IISA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 14. Race - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 11 Marital Status 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 8th Grade NA Homemaker Care Provider 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Nicholas Jones Annie Berry 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Joyce Underwood 13702 Jarrettsville Pike Phoenix, MD. 21131 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, StateMD . N☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Zion A.M.E. Ch. Cem. 05-18-2000 LongGreen 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Baltimore, Maryland 21202 21. Signature of Funaral Service Licenses WM.C.March FH 1101 E. North Avenue Part1. Enter tha disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Interval Betwaen Onset and Death PULMONARY FIBROSIS AND ATELECTASIS Immediate Causa (Final disaase or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or lawy) Dua to (or as a consequence of):

Physician /Medical Examiner Division of Vitai Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral

Director

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burst-transit completely filled in by the tunest director, page 2 should be detached for use as the burst-transit ed by the attending physician and detached for use as the burlat-trans is certificate has been signed by t director, page 2 should be detact Be Completed by Certification: To

that initiated events rasulting in death) Last	Dua to (or as a consequence of):			
Part II. Other eignificant conditions TYPE II DIABE		sulting In tha undarlying cau	use givan in Part I.	23b. Did tobacco use co	ortribute to the couse of death? 3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to complation of cause of death?
				1 ☐ Yas 2 No	t □ Yas 2 No
25. Was casa rafarred to medical axaminar?			26. Place of De	eath (Check only ona)	
1 Yas 2 No	Hospital: 1 Appatient 2	☐ ER/Outpetient 3☐ DOA	Other: 4 Nursing	Homa 5 ☐ Rasidence 6 ☐ Oth	nar (Specify)
27. Mannar of Death 1. Matural 5 Pending 2 Accident invastigati	28a. Data of Injury (Month, Day Year)	28b. Time of Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occur	red
3 Suicide 6 Could not determine		homa, farm, sfreet, factory, ify)	office	281. Location (Street and Numb City or Town, Stata)	ber or Rural Route Number,
29a. Certifier 12 Certifying P (Check only one) 2 Medical Exe	thysician: To the best of my kn miner: On the basis of examin and mannar stated.	owledge, death occurred at ation and/or invastigation, is	tha tima, date and place in my opinion, death occ	e, and due to tha cause(s) and ma curred at the time, date and place,	anner as stated. end due to the cause(s)
Oh Signature and title of Astribut		290	License number	20d Data signa	od (Month Day Veer)

D37254

TOWSON, MARYLAND 21204

5-14-00

State Registrar

Medical

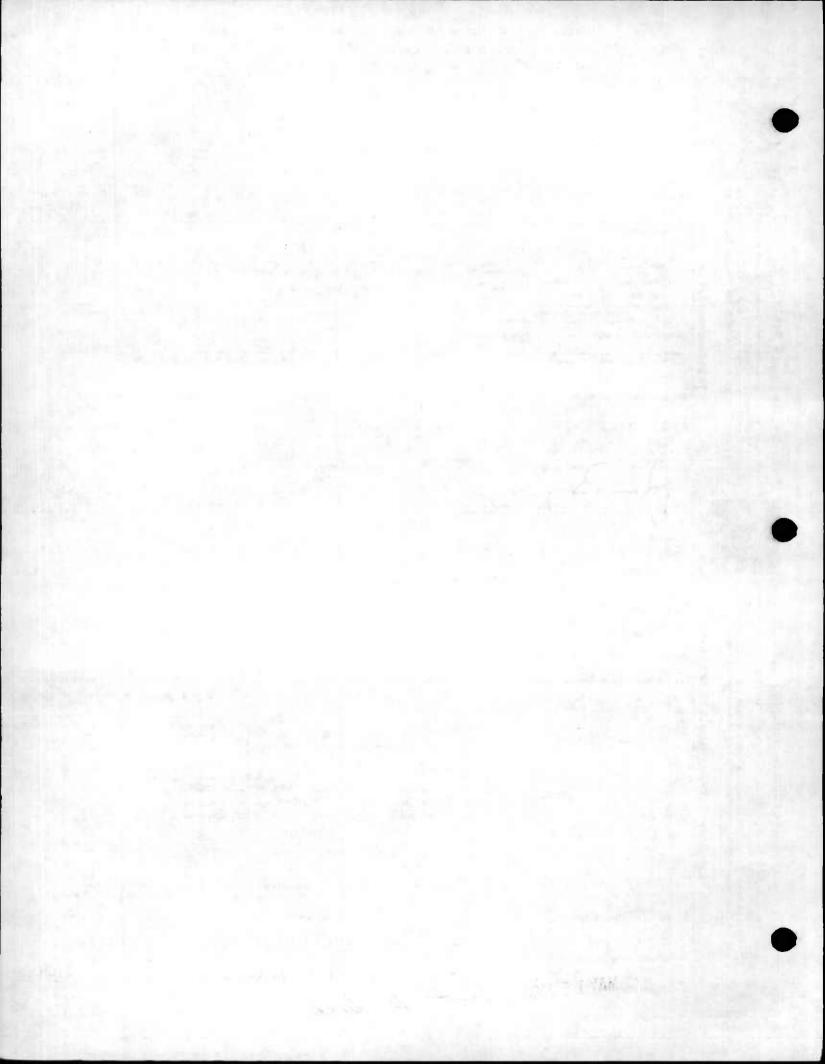
31. Date filed (Month, Day, Year) MAY 1 5 2000 32. Registrar's Signatura

30. Name and addrass of person who completed causa of death (frem 23a) (Type, Print).
BODN P. LIM M. D. 7601 OSLER DRIVE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 | 15553

/sician				Cer	tificate	OT L	<i>Jeain</i>			Reg. No.		
	1. Decedent's Neme (First, Mide	dle, Last)							2. Dete of De Month	eth Day	Year	3. Time of De
	Jessie	Mae	Mangum						May 12		Tear	12:30
ledical aminer	4a Facility Name (If not institution					41	c. City, Ton	wn, or Lo	cation of Deat	-	nty of Deat	
	Mariner Nursin	c Center				F	orest	t Hi	11	Har	ford	
eral	5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or F
tor	234 03 0046 Usual Residence of Decedent	1 M 2 F	89	Yrs.	Months	Days	Hours	Min,	June 2	23,1910	Mar	yland
rector	10a. State 10b. Count	у	10c. City,	Town or Lo	cation							10d. Inside City
ò	Manual and Dallet		200	131 - D	•							1 ☐ Yes 2
8	Maryland Balti 10e. Street and Number	liore	I MIC	dle R	10f. Zip C	ode				10g. Citizen	of What Co	untry?
ā	3727 "D" White	Pino Pos	9				1220				USA	
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by Funeral Director	1 Never Merried 2 Me 3	Armed Formed 1 Yes	orces? 2XNo ve	1	Yes, specify	_	Specify:	Puerto	cify Yes or No Rican, etc.)		lack, White city: Whi	e, etc.
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reumetic event, the Hedical To Be Completed	17. Fether's Name (First, Middle	, Last)					18. Mothe	r's Neme	(First, Middle	Maiden Sum	-	
To B	Harry Phillips					-	Jean	ette	Moore			
F	19a. Informant's Neme/Relation			19h Meilin	n Address (Street a				er, City or Tox	vn State 2	Zin Code)
		grandson)			-					Maryla		
ŀ	20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name	of			Date	20c. Locatio	n - City or	Town, Stete
	1 ☐ Buriat 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State		of Fai		-	5/15	/2000	Baltin	nore (County,
	21. Signature of Furtural Survice		Gar								nore .	councy,
	1		1						Home			
	11-17	79/2									Maryl	Land 2122
	23a. Fast. Enter the disease, or compositions that edused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line.											Approximete Interval Betwe
	V											Onset end Dea
	Immediate Cause (Final disease or condition	C	-	- 7	+ d							LT.
2	resulting in death)	a	Due to (or a	an conseq	uencerof):		-				1	LTy
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ysician/	Pert II. Other algnificant conditi	ions contributing to d	eath but not resulti	ing in the un	ndertying cau	se give	n in Pert I.					to the cause of
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#11 PER F.H. G783 5-17-2000 JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Month Sses 00 4a. Facility Nama (If not institution, giva straat and pumber) 4c. County of Death 4b. City, Town, or Location of Death N/A BON SECOR Hospital BALTIMORE If Undar 1 Year tf Under 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Age (In vrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Date of Birth (Month, Dey, Yaar) Days 15 M 20 F Months Yrs. 60 06-29-39 S.C. 251-60-3669 Usuat Rasidance of Decadent 10b. County BALTIMORE 10c. City. Town or Location N/A 10d. Insida City Limits MD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7111 PORTSMOUTH ROAD 21244 USA 12. Was Decedent Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritat Status 14. Race - Amarican Indian. Black, Whita, atc. 1 Yas 2 If Yes, Giva Year or Datas: 1 ☐ Yas 2 No Specify: 3 ☐ Widowad 4 🖾 Divorced **BLACK** 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usuat Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamentary/Sacondary (0-12) College (1-4or 5+) ELECTRICAN MUSUME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) MANTON McCLARY HATTIE PASLEY 19a. Informant's Name/Ratationship (Typa, Print) 19b. Mailing Addrass (Straat end Number or Rural Route Number, City or Town, Stata, Zip Code) HALEASE McCLARY 7111 PORTSMOUTH ROAD BALTIMORE MARYLAND 21244 20a. Method of Disposition

1. Buriat 2 □ Cremation 3 □ Removal from State 20b. Placa of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata KING MEMORIAL PARK 5-19-2000 BALTIMORE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility JAMES A. MORTON & SONS F.H. INC. Signatura of Funaral Sarvica Licensas 21217 1701 LAURENS STREET, BALTIMORE, MD 11. Enter the disease, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, or haart feiture. List only ona cause on aach lina. Approximete Intarval Between Onsat and Daath Immadiate Ceuse (Finel disease or condition resulting in death) nuh- Metur-ta month Dua to (or as e consaguanca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Dua to (or es e consequance of) thet initiated avants rasulting in deeth) Lest Dua to (or as a consequanca of) 23b. Did tobacco use contributa to the cause of death? Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings evailable prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to predical 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Depatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work?

Examiner Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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1 Natural

2 Accident 3 Suicida

4 Homicide

29b. Signature and titla of certifiar

29a. Cartifian

Certification:

Medical

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the ricilised at

Physician /Medical

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

6UIS N. KANDAN 31. Date filed (Month, Day, Yeer) MAY 1 5 2000

5 Pending invastigation

6 Could not be

29c. Licansa number

1 ☐ Yas 2 ☐ No

2 Medical Examinar: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and manner stetad. 00

28f. Location (Straat and Number or Rural Route Number, City or Town, State)

auus 30. Nama and addrass of person who completed causa of death (ttem 23e) (Type, Print)

2300 CIM

MO

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

Blud.

32. Registrer's Signetura

1 Certifying Physician: To tha best of my knowledga, daath occurrad et the tima, data and placa, and dua to tha causa(s) and mannar as stated.

g control of disk

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 15555

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Physician /Medical	ElizABET	H NG	NAN				May	1	000	0555 AM
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	Usual Residence of Decedent							7		<u> </u>
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MAY 15 2000 Brown B. Aprile

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40.5	miner	4a Fecility Nama (If not institution Genesis Elde			ge Ce			unda	lk	ocation of Death		unty of Death Ltimo:		
Fune Direc		5. Social Security Number 215-14-0327 Usual Residence of Decedant	6. Sax 1 □ M 2 X F	. Age (In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Undar Hours	24 Hrs. Min.	8. Data of Birt (Month, Da OCt. 4	, 1918	9. Birth Cou Md	nplace (State or Foreign untry)	
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5-0020 72 hours after death with the Maryland natural, or flerna 23a or 28a-f ahow	by	11. Marital Status 1 □ Naver Marriad 2 Marr 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Force 1 Yes 2 If Yes, Give Yaar or Date	es? No	U,S. 13. Was Decedent of Hispanic Origin? (Specify Yas or II Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 □ Yes 27 No Specify:						No- 14. Race - American Indien, Black, White, atc. Specify: White			
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50, e execut sian and unial-tran	i Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause. (Disease or lower	COR	Dua to (or a	Ry	nuance of):	TE	RY	DI	SEASI	2		4 YEARS	
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O. Box death certified the attending	sician	Part II. Other eignificant condition	ne contributing to deat	th but not rasult	ting in tha u	nderlying c	ause giv	en in Part I).	23b. Dld 1	obacco uae	contribute	to the cause of death?	
P.C	Phy	CHRONIC 1	9BSTRU	CTIVE	EP	ULMO	NI	ARY	DUS	EHSE "	Yes 2 P	10 30 Pr	obably 4 Unknow	
of Vital Records, P.O. Boy Physician: The law requires that the death or this certificate has been signed by the attend this director, page 2 should be detected for us	Completed by Physician									24a. Was	en eutopsy med?	9	Vere eutopsy lindings wailable prior to completion of cause of death?	
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W	(30. Name and address of person	who completed cause	of death (Itam)	23a) Type.	Prior) + (E	HIGH	twa	BAL	TIMO	RE, N	1ARYLAND	
	State istrar	31. Dete filed (Month, Day, Year) MAY 1 5 2000		Istrar's Signatu	ira /	rela							VICE ST	

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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Dey Month Year **Physician** 7:20 am Lucy Elizabeth Reed 13, May 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Agnes Nursing And Rehabilitation Center Ellicott City Howard H Under 1 Year H Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year)
March 12,1907 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 25F 93 Yrs. 214 22 8190 Director Georgia Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show Maryland Howard 1 ☐ Yes 2 No Ellicott City Director r 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 5 me 23a 3004 N. Ridge Rd. 21043 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Merital Status filed within 72 hours after thygiena.

Thygiena. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give ò 1 ☐ Yes 21 No Specify: Specify: White þ 3⊠ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied v. Department of Health and Mental Hygies Important: if item 27 is marked other the eny injury or other treumatic event, the page. Home Maker Own Home 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John Roberts Dora Hemperly 19a. Informant's Neme/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia Adams (Daughter) 3126 Brookmeed Rd. Ellicott City, Md. 21042 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☑ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Memorial Garden 5/19/2000 Douglasville, Georgia 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Approximate Intervel Between Onset and Deeth 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Myocardial Infarction Four Weeks Examiner Due to (or as a consequence of): Examiner for usa as the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): law requires that the death certificate be execu Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2⊠ No 3 Probably 4 Unknown Fracture of Left Femur þ page 2 should be 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy peen Renal Failure PH-1 ☐ Yes 2 No 1 Yes 2 No certificate al or Attending Physician: The star death.

Journal of the star of director. 25. Was case referred to medical exeminer? 26. Placa of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4☑ Nursing Home 5☐ Residence 8 ☐ Other (Specify) Certification: To 1 Yes 2 No funeral 27. Menner of Deet 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. fnjury et Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) Medical

Division To the Hospital or within 24 hours aft To the Funerel DI completely filled in

Records,

of Vital

21215-0020

Baltimore, Maryland

State Registrar

DHMH 16 Rev 6/95

VELLANKI, MD, 31. Date filed (Month, Asy, Year) 2000

29b. Signeture end title of certifier

9055, Chevrolet Drive, #100, Ellicott City, MD 21042. 32. Registrar's Signeture

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 30469

29d. Date signed (Month, Day, Year)

15th

May

2000.

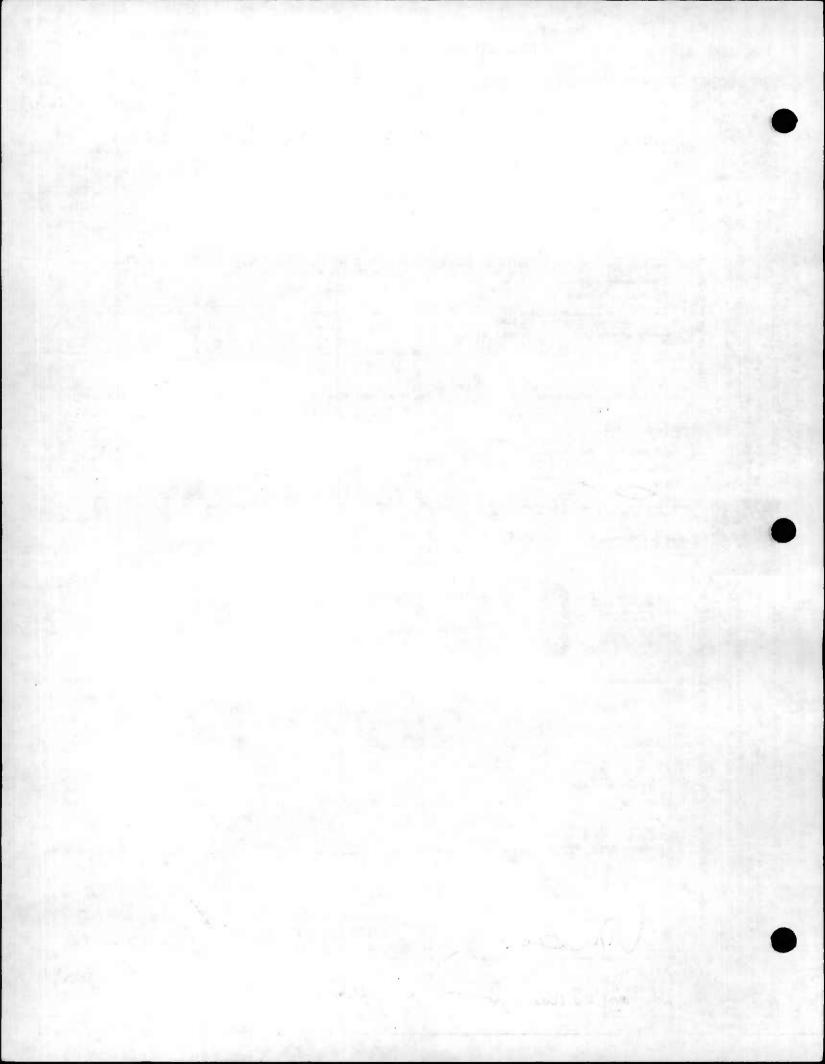
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

BERT	ROBERTSO	ON AMEND#11 PER INFMNI. G7	State of Maryland	/ Department Certificate			- 0		5558		
		1. Decedent's Name (First, Middle, La.		Certificate	OI Deall1	2. Date of Death	g. No. O		3. Time of Death		
	Physician	ROBERT S	. ROBERTSON			Month MAY	09	Year 2000	18:53		
	/Medical Examiner	4a Facility Name (II not Institution, give			4b. City, Town, or	1	·				
		536 LUCIA AVENUE				IMORE	ORE N/A				
	Funeral	5. Social Security Number 6. S	M 2□ F	Months [Year If Under 24 Hrs Deys Hours Min	(Month, Day,	Year)	9. Birthple Count	ace (Stete or Foreign		
	Director	213-32-3934 Usual Residence of Decedent	65	Yrs.		02-25	-35	Count	MD		
	and land	10a. State 10b. County	10c. City,	Town or Location				10	d. Inside City Limits		
90	Marylar Fed at for	MD N/A		BALTIMO	RE.				1 Yes 2□No		
	vith the Mar or 28s-f a be notified Director	10e. Street and Number		10f. Zip C		10	g. Citizen of V	Vhat Count	ry?		
	death with the Maryland ms 23a or 28a-f show rmust be notified at neral Director	536 LUCIA AVENUE		21	1229		U	SA			
	ors after al., or he Exercise by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed ★ Bivorced	12. Was Decedent Ever In U,S Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify	if of Hispanlc Origin? (S Cuban, Mexican, Puer (No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	pecify Yes or No- Black, White, Specify: BLA				
2-0	72 ho	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual (Occupation done during most of wo	rking 1	6b. Kind of Bu	siness/Indi	ustry		
2	E	Elementary/Secondary (0-12)	College (1-4or 5+)	FICER							
2	il Hygiene offher the	2			S GOVT						
and	B se se	17. Father's Name (First, Middle, Last)		me <i>(First, Middle, M</i> CINE ROBER		10)					
Z	alth and Menta 27 Is marked or traumatic o	ROBERT A. SMITH 19a. Informent's Name/Relationship (Time Printl	19b. Mailing Address (5				State Zin	Codel		
Ma		CHERYL LAPRADE /			DDLEBACK RE				5000)		
ē,	f Health from 27 other tr	20a. Method of Disposition	20b. Pia	ce of Disposition (Name	of	Date 2	Oc. Location -	City or Tov	vn, State		
E O	20 = 2	Burial 2 Cremation 3 Donation 5 Other (Specific	Hemoval from State	netery, crematory or other NATIONAL C							
Baltimore,	parmit. Pag Department Important: I any Injury o ence.	21. Signature of Funeral Service Licen		JAMES A	Address of Facility 8	SONS F.F	I., INC				
	Paris I	Part1. Enter the disease, or comshock, or heart failure. List only	pliotions that caused the death		AURENS ST.				Approximate		
	the personned was executed whistoin and the purish-transit the purish-transit and incar Examiner dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	as a consequence of):	cerebral	hemore	hage				
	as that the death certificate signed by the attending phys be detached for use as the by Physician/Medic	resulting in death) Last	Due to (or a	as a consequence of):							
O. B	the att hed fo	Part II. Other significant conditions of	onfributing to death but not result	23b. Did tobacco use contribute to the cause of death							
P.0	ed by the datached datached	Cheenic	narcotism			1 □ Ye	8 20 No	3 Prob	ably 4 Unknown		
ec	al Records, P The law requires that the law requires that the been signed b page 2 should be delt Completed by PI		, , , , , , , , , , , , , , , , , , , ,			24a. Was an perform	led?	ava com of d	re autopsy lindings ilable prior to opletion of cause eath?		
Ita	certificata rector, pag	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)				
of V	SE T	1 X Yes 2 No		R/Outpatient 3□ DOA	1	lome 5X Reside)		
vision	After fune	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	(Month, Day Year)	28c Time of Injury M	28f. Location (Str	28d. Describe how Injury occurred 28f. Location (Street and Number or Rurel Route Number, City or Town, State)					
	Funer Funer etaly fill dical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowliner: On the basis of examination and manner stated.	ledge, deeth occurred at on and/or investigetion, in	the time, date and place my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and ma te and place, a	nner as sta and due to	ated. the cause(s)		
	within 2 To the comple	29b. Signature and title of certifier	A	29c. L	icense number	29	d. Date signed	d (Month, E	Day, Year)		
		Arunh	d 1/ us	At un	O.C.M.E		MAY 10	200	0		
	0	30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)	O.C.M.E	•	MAI IU	200	U		
		Stephen S.	Radentz		Street, B	altimore.	Maryla	and 2	1201		
	State Registrar	31. Date filed (Month, Day, Year) MAY 1 5	2000 32. Registrar's Signatu	ire /	backs						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, 5 5 9 State of Maryland / Department of Health and Mental Hygiene

ysician 1edical	1. Decedent's Name (First, Middle, Las	10)					2. Date of Do	Reg. No. eath Dey	Year	3. Time of Death
iculval :	ANN O. REPP						May	13 2	000	12:26 A1
miner	4a Facility Name (If not institution, give	street and number)	1 1				Location of Dea			
_	Franklin Squar 5. Social Security Number 0 6. S	re 170501	Tal (In urs last hi	enter	ler 1 Year	If Under 24 Hr	dale S. 8 Date of Bi	Dal	tim	of Colors of Fornio
ral tor	215283615 Usual Residence of Decedent	_M 2K] F	90	Yrs. Month	s Days	Hours Mir	JULY 1	ay. Year) , 1909	RUS	place (State or Foreigntry) SIA
	10a. State 10b. County		IOc. City, Tov	n or Location	17				1	10d. Inside City Limits
to	MD BALTIMO	RE	ESSE	X						1 Yes 2 No
Funeral Director	10e. Street and Number		- 11/11	10f. 2	Zip Code			10g. Citizen of V	Whet Cour	ntry?
2	2328 BARRISON POI				212			USA		
2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2/2/No If Yes, Give Year or Detes:			sedent of H becify Cube 2012 No		Specify Yes or Norto Rican, atc.)	o- 14. Rac Blac Specify	k, White,	can Indien, etc. HITE
	15. Decedent's Ed (Specify only highest gra-		16a	. Decedent's Us	vork done o	during most of w	orking	16b. Kind of Br	usiness/In	dustry
ĺ	Elementary/Secondary (0-12) UNK	College (1-4or 5+)		SEAMS)		CLOTHI	NC	
ŀ	17. Father's Name (First, Middle, Last)	UNK.		SEARIS	IVESS	18 Mother's Na	me (First Middle	e, Meiden Surnan		
	UNK	UNK					ino (1 1131, 1111001		,0,	
ŀ	19a. Informant's Neme/Relationship (1			o. Mailing Addre	ss (Street	UNK .	Rural Route Numl	UNK .	State. Zir.	Code)
	JOSEPH REPP/ STE			-				ALTIMORE		
1	20a. Method of Disposition			f Disposition (A ny, cremetory of DON PAR			Date	20c. Location -	•	
	1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		LOU	DON PAR	K		5/15/00	BALTIMO	RE, I	MD
-	21. Signature of Euroral Service Conn	100		22. Name	and Addres	ss of Fecility	VERAL HO	ME		
	16 75			1211	CHESA	CO BAL	VEKAL HU FIMORE	ME MD 21237		
	23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only	plications that coused the	ne deeth. Do						1	Approximate Intervel Between
	and an industrial and a control of the								- 1	Onset end Deeth
	Immediate Cause (Final disease or condition	. Preu	non	ia					1	3 Days
	resulting in death)			consequence o	f):					5 Days
edical Examine		b. Stro	, Ke							5 Days
	Sequentially list conditions, if any, leading to immediate	D	ue to (or as a	consequence o	f):					1
Ì	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	С.			n	-			1	
3	resulting in death) Last	Di	e to (or as e	consequence of):				1	
2		d								
Physician	Part II. Other significant conditions co	ntributing to death but	not resulting i	n the underlying	cause giv	en in Pert I.	23b, Dld	tobacco use co	ntribute to	o the cause of deat
è							10	Yes 2 No	3 ☐ Pro	bably 4 Unknow
6							-			
Completed								s an autopsy orned?	av.	ere autopsy findings eilable prior to
9									of	mpletion of causa death?
							10	Yes 2 No	1(Yes 2 No
	25. Wes case referred to medicel examiner?	Hospital:			Oth		eth (Check only	one)		
1	1 Yes 2 No 27. Manger of Death	1 25 Inpatient			JOA	4 LI Nursing		idence 6 Oth		'y)
Contraction	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day)	'ear) 200.	Time of Injury M	28c. Injun Worl	k? Yes 2 □ No	200. Describe	how injury occur	190	
	3 ☐ Suicide 6 ☐ Could not be		- At home. I				28I. Location	(Street end Numi	er or Run	al Route Number,
	4 Homicide	building, etc.	(Specify)				City or To	iwn, Stete)		
BOID	29a, Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of a lner: On the basis of e and manner stete	caminetion ar	e, deeth occurre	od et the tim	ne, date end plac pinion, deeth occ	e, end due to the curred et the time	cause(s) and me , date end place,	enner as s and due to	stated. the cause(s)
	29b. Signature and Jillie of certifier		. 17.1	2	9c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
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	\ \\h. C	14				1 7 7 7		1 1 4 4 4	7	OOO



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 6:25 A.M 5 MARY RACHEL RICH
4a Facility Nama (If not institution, give street and number) 00 RICHWINE /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE HRMILTON GENESIS CENTER
5. Social Security Number 6. Sax 7. Aga If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Months Days Hours Min. 3 24 - 19 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** 1□M 28F Months 94 Yrs. 212-05-8847 Usual Rasidanca of Decedant -24-1906 OHIO Director the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mentel Hygiene.
ant: If item 27 is marked other than "naturel", or items 23e or 28a-f show ury or other trsumetic event, I'm Modical Examinat must be notified. 1 PYes 2 □ No Director LUTHERVILLE MD BALTIMORE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 807 USA BARNFORD CT. 21093 Funeral 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 1 Yas 2 No It Yas, Giva Year or Detes: 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Specify: Maryland 21215-0020 þ 3 ₩Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) MFG HAT MAKER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be 2 JOHN LUKE BARBARA WILLIE 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Rev. Earl D. Baldwin Friend 801 James of Community Community of Other Place of Disposition (Nama of Community Commun 807 BARNFORD CT LYTHERVILLE MD. 21093 Baltimore, Dete 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any injury or ot
once. DULANEY VALLEY MEM. GARDENS 5/16/00 BALTIMERE, MD

22. Nama and Address of Facility
ALTENBURY FUNERAL HOME, P.A. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensae

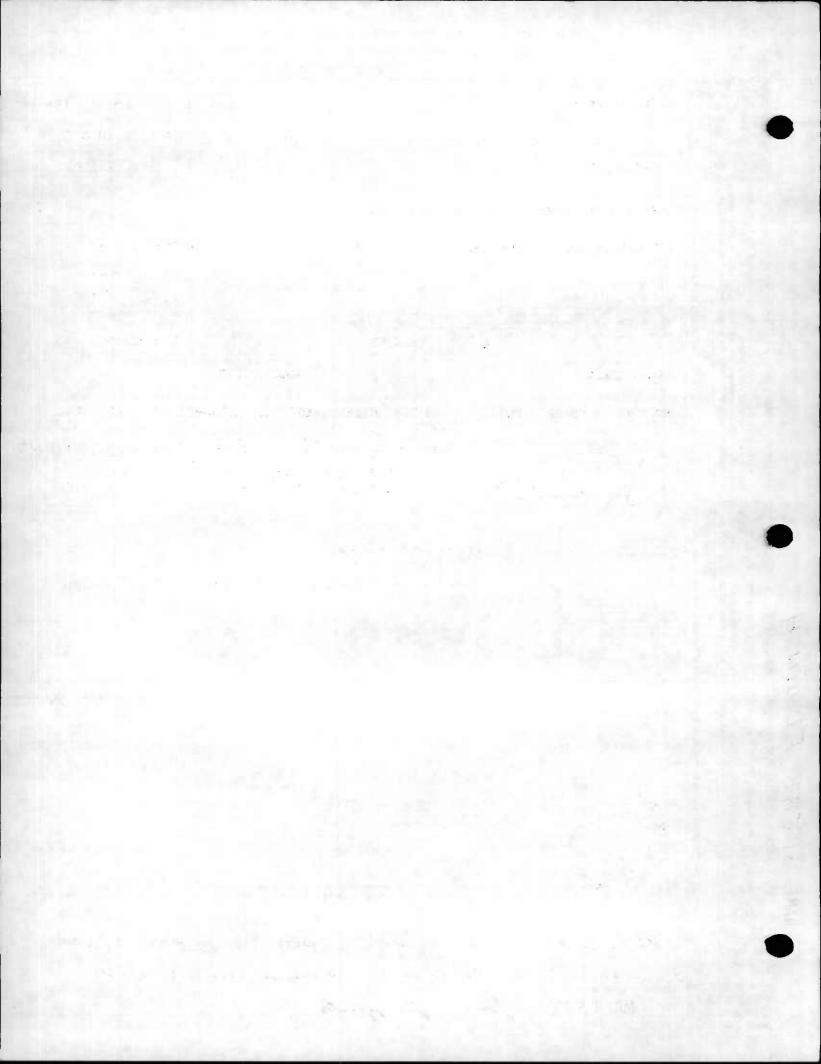
ROBERT C. PLTENBURG. prout 8. altel Lic Docce 2 6009 HARFORD ROAD BALTO, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death **Physician** /Medical Immediata Causa (Final olden disaasa or condition rasulting in death) Examiner Due to (or es a consequanca of): Examiner mumes that the death certificate be executed physician and s the bunal-transit Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaase or Injury that initiated avants rasulting in death) Last to (or as a consequanca of): Physician/Medical Dua to (or as a consaguanca of): attending pl for use es t signed by the a d be detached f Part II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Division of Vital Records, þ 24b. Wera autopsy findings available prior to completion of causa of death? been si 24a. Wes en eutopsy performed? Completed After this certificate has I funeral director, page 2: 1□ Yes 2 No 1 Yas A No I or Attending Physician: after death. Be 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas SZ No 2 28e. Date of Injury (Month, Dey Year) 28b. Tima of Injury 28c. tnjury at Work? 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant ector: / 6 Could not ba datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida 28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) when 24 hours after To the Funeral Directory filled in by 4 Homicida 1 A Cartifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piece, and due to tha causa(s) and menner es stated.
2 Madical Examinar: On the basis of axamination and/or investigation, in my opinion, deeth occurred at tha time, date and piece, and due to the cause(s) and mannar statad. 29a. Certifiar Medical 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and titla of certifier Martner 30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print) Norther baltimore arhurey 32. Registrario Signatura 31. Data filad (Month, Day, Yaar) **State** MAY 1 5 2000 Registrar

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 15561 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death Dav Month Yaar **Physician** EDWIN H. SPEAR 1300 MAY 12 2000 /Medical 4e Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Baltimore BALTIMORE CITY Agnes Healthore | Brunder 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | 9. Birthplace (Steel Min. | APRIL 24, 1906 INDIANA If Undar 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) 9. Birthplace (Stata or Foreign **Funeral** Days Months 94 216-20-9953 Director Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BALTIMORE COUNTY CATONSVILLE 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g, Citizan of Whet Country? Examiner must be 715 MAIDEN CHOICE LANE C-106 21228 UNITED STATES Funeral 12. Was Decadent Evar in U,S Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Reca - Amarican Indian, Black, White, etc. 1 ☐ Never Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: by 3 Widowed 4 □ Divorced WHITE 15. Decedant's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "1 any injury or other traumatic event, the Mes Collega (1-4or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be GRACE WELTY ISAAC SPEAR 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 9755 CYPRESSMEDE DR., ELLICOTT CITY, MD 21042 DOUGLAS S. SPEAR / SON 20b. Placa of Disposition (Nema of camatary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1⊕ Burial 2 □ Cramation 3 □ Removal from Stata
4 □ Donation 5 □ Other (Specify) MAY 2000 GLEN HAVEN MEM. PK. GLEN BURNIE, MARYLAND 5 Other (Specify) eral Service Licensee OL EN RIKKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Daath **Physician** Immediate Ceuse (Finel disaase or condition rasulting in death) /Medical Hemmorhage Examiner Dua to (or as a consequence of) Ruptured Abdominal Aortic Acurysm Examir Sequantially list conditions, if eny, laeding to Immadiete cause. Entar Undarfying Ceuse (Disaasa or injury that Initiated avents rasulting in daeth) Last Due to (or as a consequanca of): Physician/Medical Due to (or as a consequenca of): 8 EDWIN Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings availebla prior to complation of causa of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Tyes 2 No. certificate 25. Was casa rafarrad to medical Be 26. Piece of Death (Chack only ona) exeminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 報 28c. Injury at Work? 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Tima of 28d. Describe how Injury occurred Naturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be detarmined 3 Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 28e. Placa of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) Hospital or At 24 hours after of Funeral Direct 4 Homicide 24 hours a edical 29a. Cartifian 🔼 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to the cause(s) end menner as steted. (Check only one)

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) end manner stated. Within 2 Forther 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Dete signed (Month, Dey, Year) Surgery mo Rosilent Department of P10878 2000 30. Nama and address of person who completed cause of daeth (Item 23e) (Type, Print) Elie K. Fraisi, Ir. 900 Cuton Ave Bultimore, Moryland 21229 MID 31. Data filed (Month, Day, Year) 32. Registrer's Signeture State Registrar MAY 1 5 2000



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	5. Social Sec		ic Genera	1 Hospi 7. Age (In yrs.		If Under 1 Year	Berlir			rcester	te or Foreign		
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23a or 2 met be n al Dire	10e. Street ar 221 Str	atford Dri	ve			10f. Zip Code	15642		10g. Citizen of V	Vhel Country? USA			
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Department of Heath and Mental Hygiene. Important; If Item 27 ie marked other than any Injury or other traumatic event, the Mence. To Be Compi			30Removel from	Cinto	Plece of Disposit cemetery, creme in Catholi ION CEME	tory or other ple		Dete	20c. Location -	City or Town, Stele PA			
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State of Maryland / Department of Health and Mental Hygiene 5563 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Ma che 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BaltimoreCity Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M XXF Months Hours Yrs. Director 201-01-1182 82 21,1918 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mentel Hyglene.
ant: if Item 27 is marked other than "natural", or frams 23e or 28a-f show ury or other traumatic event, the Mod cal Examinat must be notified at XXYes 2 □ No Directo MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 3400 O'DONNELL STREET Funeral 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Merried Maryland 21215-0020 1 Yes 2 No Specify 2 Specify: 3X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 CROSSING GUARD BALTIMORE CITY SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL MIZERACK 2 HELEN COPAC 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE SOBUS/ DAUGHTER 1724 SEARLES ROAD, BALTIMORE, MARYLAND 21222 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Peges 1 Department of H Important: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 5/15/00 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND 22. Name end Address of Facility LILLY & ZEILER INC. FUNERAL HOME 21. Signature of Funeral Service Licenses 700 S. CONKLING STREET BALTIMORE MARYLAND 21224 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) ocandial Examiner Examiner Ante on on. The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burie Box 68760 Ana Due terfor as a consequence of): Physician/Medical Higertenzion Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Were sutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 2 No 1 Yes 254No 1 Yes or Attending Physician: 25. Was cese referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural s efter deep... 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in within 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical pletely (Check only 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 42414321 SEA 1 hes da 2000 - 12 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Wolfe Street Baltimore, 600 +8SISAM 1 headore NorTh Tierre 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 5 2000 oaks Registrar

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State of Maryland / Department of Health and Mental Hygienen 5565 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:35 PM Mordecai Sinckes Mai 2000 11 /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. | 8
Months Days Hours Min. Sinai It ospital City N/A 8. Date of Birth (Month, Day, Year) MAR. 2,1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 10 M 20 F 89 Vrs 150-30-1183 N.Y. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3429 PHILIPS DRIVE 21208 238 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give T Year or Dates: or items Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status filed within 72 hours efter 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ WHITE 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry pernit. Peges 1 end 2 should be filed withir Department of Heelth end Mental Hygiene. Important: If Itam 27 is marked other than any Injury or other traumatic avant me Elementery/Secondary (0-12) College (1-4or 5+) 5+ RABBI JUDAIC STUDIES 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumerne) Be MORRIS 2 SIMCKES MINNIE REIZES 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN SCHNEIDER / DAUGHTER 3429 PHILIPS DRIVE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel Irom State CONG. SHOMRAY HADATH 5/14/00 ELMIRA, NEW YORK 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Facility SOL LEVINSON & BROS., 21. Signature of Funerel Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel diseese or condition resulting In deeth) /Medical Multi-system organ Examiner days Due to (or as a consequence of): Physician/Medical Examiner Acute Pancreatitis LAIRE attending physician end for use as the bunal-transit The law requires that the death certificata be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Due to (or es a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown Aortic valve disease Records, 24b. Were autopsy lindings available prior to completion of cause of death? page 2 should Be Completed 24a. Wes an autopsy 1 Yes 2 No 1 Yes 2 No certificate of Vital or Attending Physician: director. 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To this funeral 27. Menger of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident To the Hospital or Attend within 24 hours after deat To the Funeral Diractor: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completaly filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a, Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) May RES-000 M.D. 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Jonathan 2401 West Belvedere Avenue, Baltomore, Maryland 21215 M. Gerber 31. Date filed (Month, Dey, Year) MAY 1 5 2000 32. Registrer's Signature State Registrar

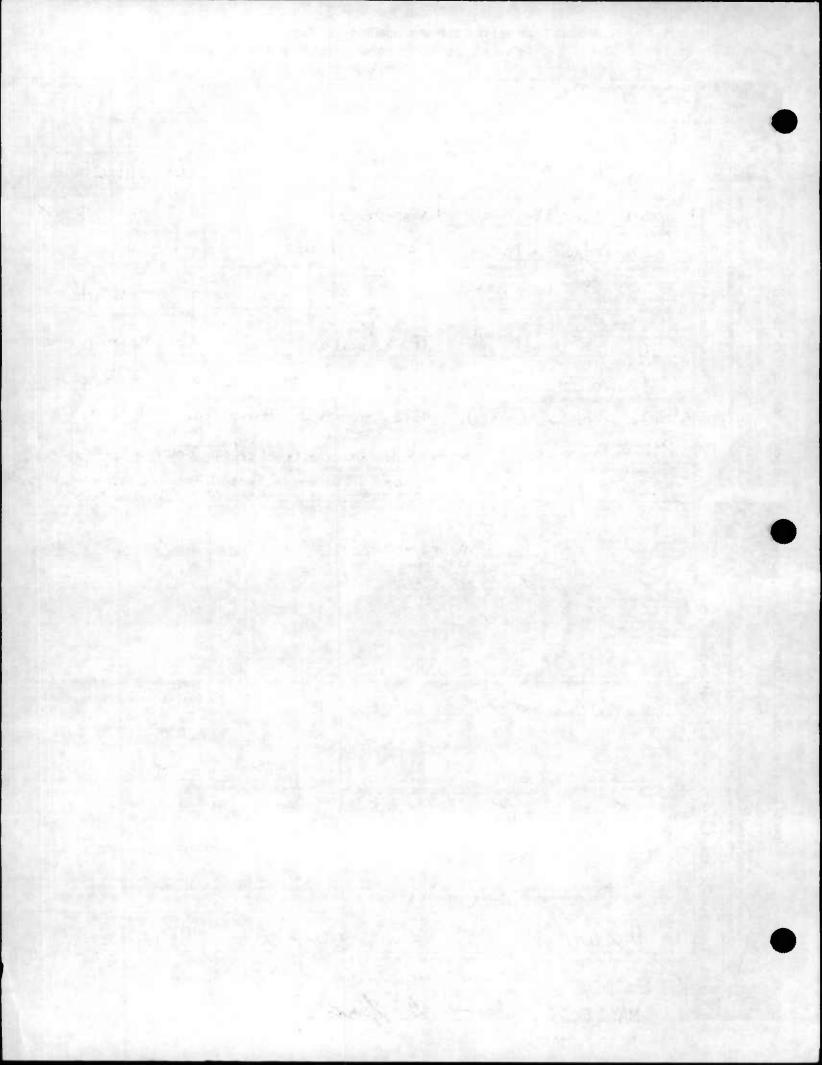
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State of Maryland / Department of Health and Mental Hygien 0 | 5566

AMEND ITE	M: #22 PER 22 PER F.H. G7	83 5-15-00 WR.	Certificate	e of Death	Re	g. No.	10000
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Physiciar /Medica	Kalon CI		homas		MAY 1	0 2000	3. AM
Examine	4a Facility Name (thinot institution, give s	treet end nymber)	0//	4b. City, Town, or	Location of Death	4c. County of E	eath
	5. Social Security Number 6. Sex	7. Age (In yrs. Ia	(st hirthday) If Under	A SOUTH THE RES	S. 8 Date of Birth	9	Birtholace (State or Foreign
Funeral Director		M 20 F /9	Yrs. Months	Days Hours Mir		930 0	Birthplace (State or Foreign Country)
2	Usual Residence of Decedent				7	100 11	
anytan ahow dat	10e. State 10b. County		Town or Location	\			10d. Inside City Limits 1 ☐ Yes 2 No
the Ma	Mayland Carrol	1	tampstea 101. Zip	Code	10	g. Citizen of What	
E 88 5	11233	act / L	101.2.0	1074	- 10	125.A	Country
her death r hame 23 siner must	11. Merital Status	2. Wes Decedent Ever in U,S	i. 13. Was Deced	ent of Hispanic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No-		American Indian,
0 4 40		Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2	./	no riican, etc.)	Specify:	Vhite, etc.
5-002(72 hours a netural", o doal Exam		Year or Dates:					White
1 21215-0 ed within 72 ho ygiene. er then 'netur f. the Medical	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's Usua (Give kind of work life. DO NOT us	k done during most of we	orking	6b. Kind of Busine	ess/Industry
212 212 1 with line.	Elementary/Secondary (0-12)	College (1-4or 5+)	- 1 7	river		ounty	Government
be file d offse event,				18. Mother's Na	me (First, Middle, M	aiden Sumeme)	
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Mar 12 sh 18 m 18 m 18 m	19a. Informant's Name/Relationship (Typ			(Street and Number or F	The second second		1
Hand San	Rolande Thomas 20a. Method of Disposition	(wifc)	4322 Dogu	ne of	ampstea	Oc. Location - City	Z1074
nor mind	1 Buriai 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emovei from Stete	metery, crematory or of	ther place)	May 12, -		
altir anterior injure	21. Signature of Fugeral Service License		ey Valley Mo	Address of Facility		monion	0
W Segra	NA310	0	Brian	T. Chisholine	Funeral Se	rvices of	f Dulaney Valley F.
NAME OF TAXABLE PARTY.	Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	Do not enter the mode	of dying, such as cardio	ac or respiratory erre	st,	Approximete
Physician	Shock, of heart failure. List only on	e cause on each line.	, , ,	- 1	1		Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	Large Kigh	+ Cerebral I	interest with	hemoreha	ciclonvers	son 24/raves
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Il Records, P.O. Box The law requires that the death ce are has been signed by the attendi: page 2 should be deteched for use		JERHALL G					
O of the de	Part II. Other significant conditions conf	tributing to deeth but not result	ting in the underlying ca	ause given in Pert I.			buts to the cause of death?
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BCOrd aw require ts been si 2 should				ENGEL I	perform	607	available prior to completion of cause of death?
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Of Vita Physician: this certific ral director.	1 Yes 2 No H		R/Outpatient 3 DO		Home 5 Resider		Specify)
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Division or Attending I after death. Director: After I in by the tune	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon			28f. Location (Str	eet and Number o	or Rural Route Number,
Division of the control of the contr	4 Homicide	building, etc. (Specify)			City or Town,	State)	
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To the Hosp To the Fune completely fi		and manner stated.					
Total s	29b. Signature and title of certifier		290	License number	29	d. Date signed (A	
	your, Mis			12440		5/10/2	000
1/M	30. Name end eddress of person who cor	mpleted cause of death (Item	23a) (Type, Print)	Lance Man	1.12.	201	
State	31. Dete filed (Month, Day, Year)	32. Registrar's Signatu	HO -	11-000 /11/91	ypond 210	701	
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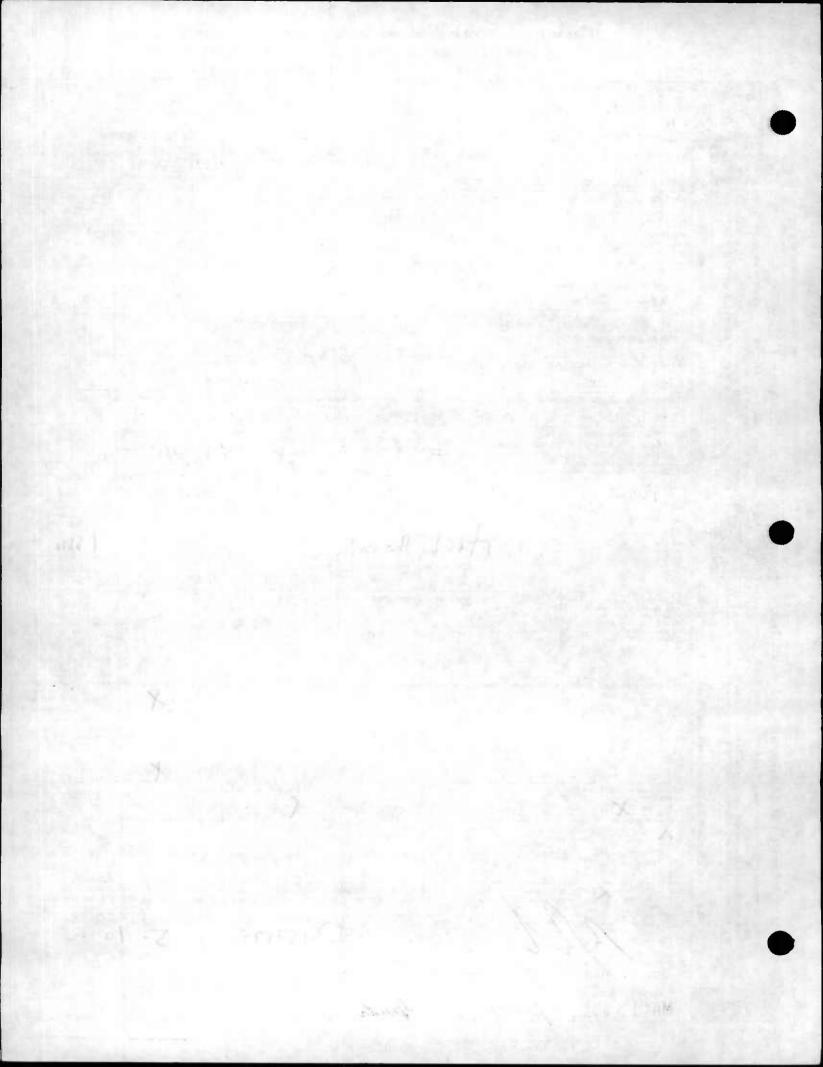
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State of Maryland / Department of Health and Mental Hygiene amend item 8 per fh G783 5/15/00 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 2000 7:12 P.M. Joseph A. Vittek May 5 /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rosedale Baltimore 8. Data of Birth 4/17/25 04/17/2000 If Undar 24 Hrs. 5. Social Security Number If Undar 1 Yaar 9. Birthplaca (Stata or Foraign 7. Age (In yrs. last birthdey) **Funeral** Deys Months Hours 15 M 20 F MD. 219-16-4378 75 Director Usuat Rasidenca of Decedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits tem 27 is marked other than "natural", or items 23s or 28s4 show other traumetic event, the Medical Examinar must be notified at 1 Yes 2 No Director Md. Baltimore Eastwood 10e Street and Number 10f Zin Code 10a. Citizen of Whet Country? 413 Pembrooke Avenue 21224 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, 11. Maritat Status Black, Whita, etc. filed within 72 hours after 1 Nevar Married 2 Merried 1 ☐ Yas 2 No If Yas, Giva Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast greda complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hygien important: If Hem 27 is marked other than any Injury or other traumetic event. The Bus Driver MTA 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Joseph Vittek Mary Peterka 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Linda Miller Daughter 413 Pembrooke Ave. Baltimore, MD. 21224 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata cemetery, cremetory or other place) Burial 2 Cramation 3 Removel from Stata Sacred Heart of Jesus Cem. 05/11 Baltimore, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensee Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD. Baltimore, MD. 23a. Part1. Enter the disease, or complications the Caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line. Approximete triterval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Mo Examiner Dua to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Diseese or injury that initiated events rasulting in daath) Last Due to (or as e consequance of): P.O. Box 68760 Physician/Medical Due to (or es e consequance of) 23b. Did tobacco use contribute to the cause of death? Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. the à 1 Yes 2 No 3 Probably 4 Unknown Records, by been signe should be 24b. Wara autopsy findings eveileble prior to completion of cause of death? 24a. Wes an autopsy performed? Completed has page 2 1 Tas 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

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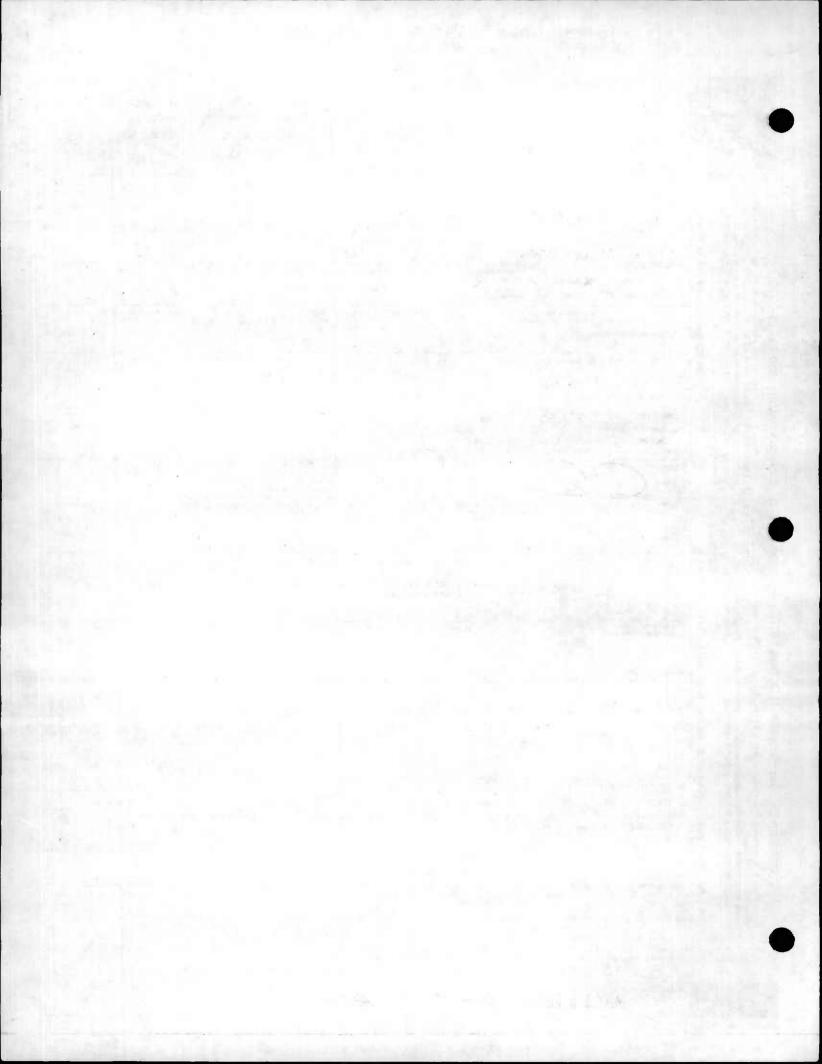
Nursing Homa 5 □ Residance 6 □ Othar (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA edical Certification: 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how Injury occurred Natural 2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 ☐ Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) manner stated. 29a. Certifiar 29d. Data signad (Month, Day, Year) 29b. Signature and title of Sentit 29c. Liceosa numbar 0-00 person who completed causa of death (Item 23a) (Type, Print) 10 17 Fontana Lane #105 Balto. Md. 21237 Dr. M. Rahnama 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State MAY 1 5 2000 Registrar



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							Cer	titicat	e of	Death			Reg. No	00		
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/Medic Examin		4a Facility Name (If not institution				. 1				4b. City, Tov	wn, or Lo	ocation of Dea	th 4c	. County o		0.00
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ges 1 er t of Hee if item 2 or other		20a. Method of Disposition 1 ■ Burlel 2 □ Cremetion	3 Dem	ovel from	State	20b. Pla	ace of Dispos metery, crem	sition (Nan	ne of ther ple	ce)		Dete				wn, State
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Baltimor permit. Peges ' Department of H Important: If ite any injury or of page.		21. Signature of Funeral Service	Licensee				22.	Name en	Addre	sedale	Fur	eral H	ome			
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6		30. Neme and address of person NACHUM P	who comp	leted cau	se of de	eath (ttem	1	Print) 918	Rid	ge Ro	1. 8	saltin	iore	ne) 3	11237
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a per phys. G783 5/15/00 yg Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** Bonnie R. Clayton 2000 April 6 /Medical 8:20 PM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months 1□ M 25 F 215-48-7921 Director May 15, 1913 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f shother the Medical Examiner must be notified at Allegany Yes 2 No Luke Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 303 Pratt Street 21540 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Detes: 1 Never Married 2 Married Maryland 21215-0020 1□ Yes 2□ No Specify: à Specify: White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working title. DO NOT use retired) 15. Decedent's Education (Specity only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o Wilford Brumback Maude Belle Shipe 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Tom Clayton/Son 303 Pratt ST, Luke, Md 21540 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Queens Point Cemetery 4/10/2000 Keyser, WV 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Boal Funeral Home, 111 Church Street 23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth Physician Systems organ Failure / fled cal Immediate Cause (Final disease or condition resulting in death) E tam ner Examiner VILLOUS ADENOMA, CARCINOMA IN SITU OF RIGHT COLON physician end s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury fhet initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 88 use Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably Unknown Villaus adenoma, (avcinoma-in-situ 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed of RIGHT Colon completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funerel director Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral process. 1 Naturaf 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1th Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and plece, end due to the cause(s) and manner stated. 29a. Certifier edlcai (Check only one)

State Registrar 29b. Signature and title-of certifier

Lober

MD

32. Registrar's Signature

30. Name and address of person who completed ceuse of deal (Item 23a) (Type, Print)

0 2000

29c, License number

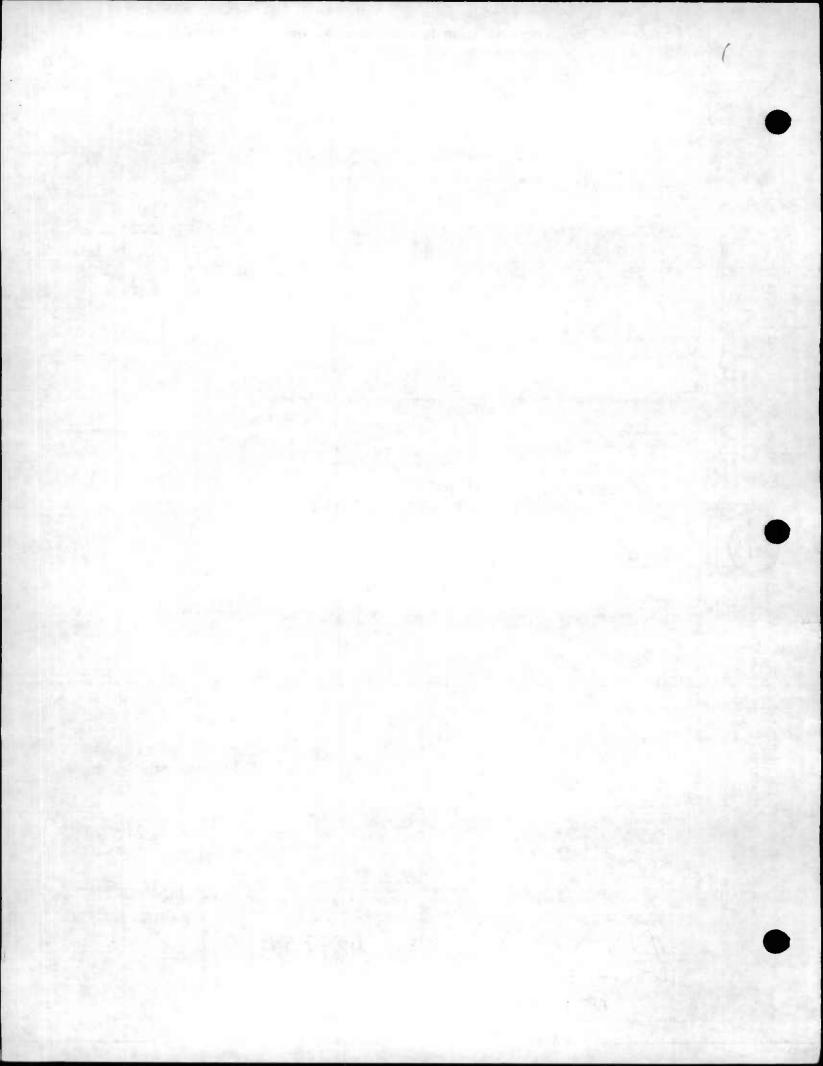
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29d. Date signed (Month, Day, Year)

April 07

Cumberland, MD Z150Z



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 GINDER PMEHTA CENTER

32. Registrar's Signature

HOSPITAL

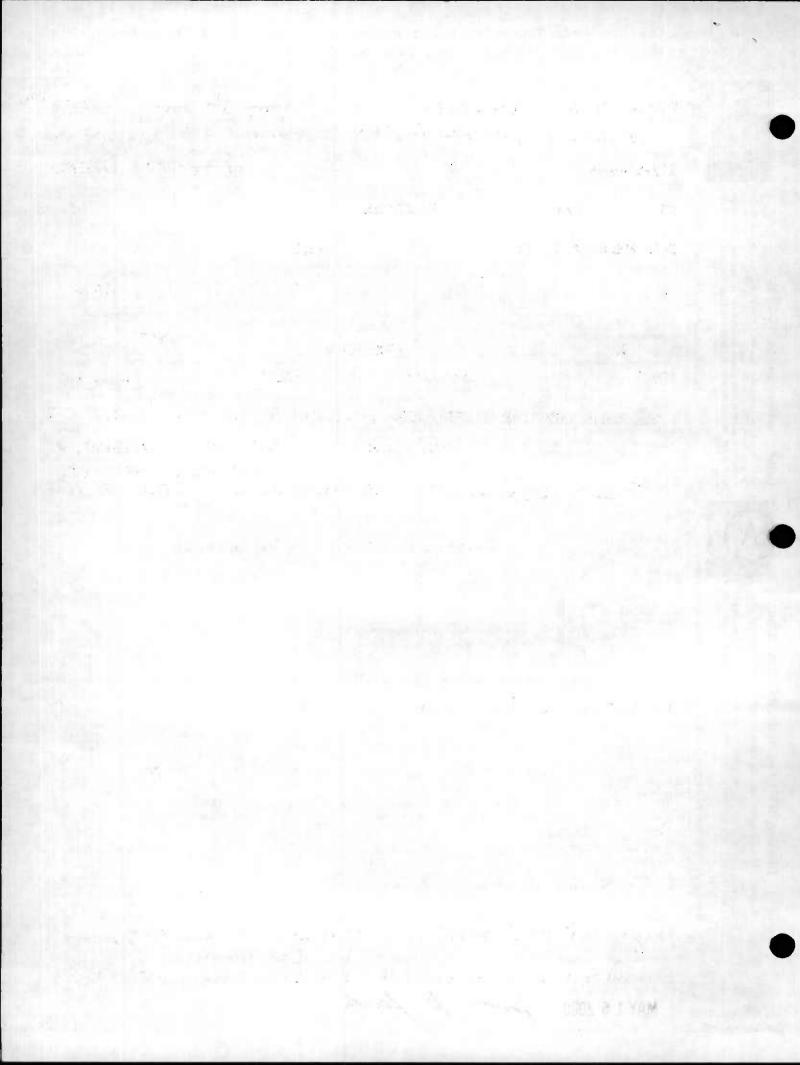
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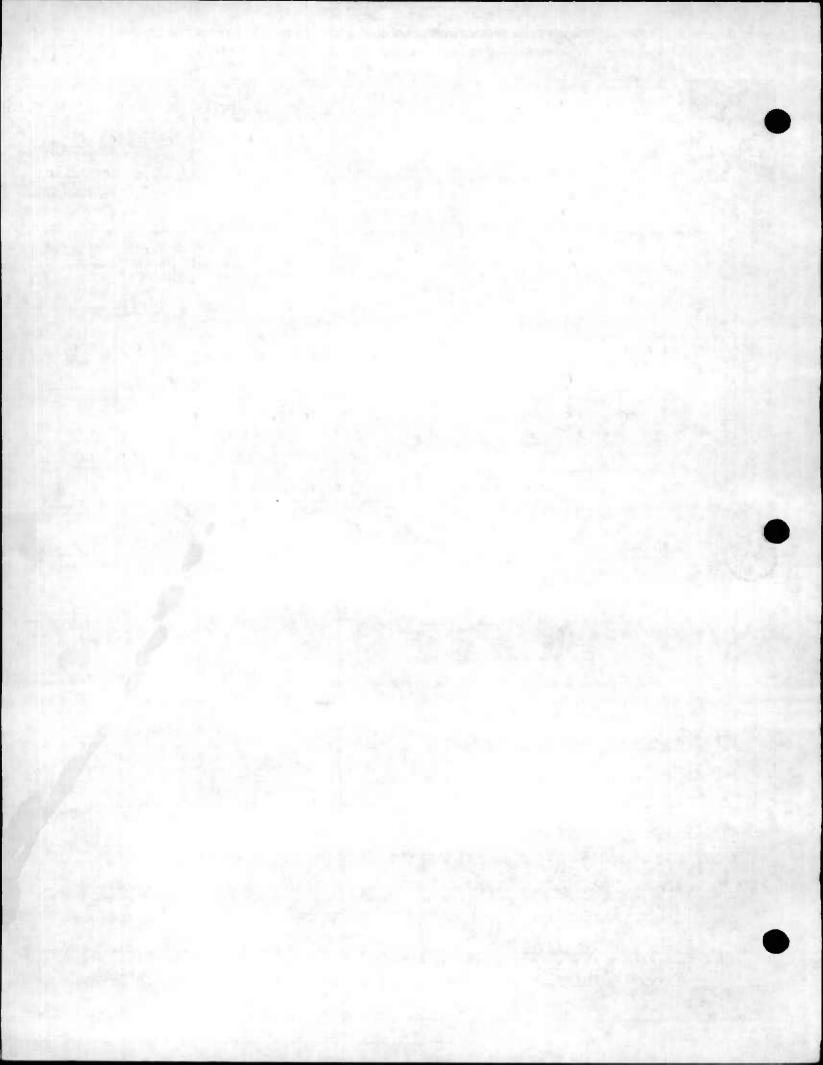
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31. Date filed (Month, Dey, Year)



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amend item 24a per phys. G783 5/15/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Yes **Physician** James B. Fazenbaker 8, April 2000 6:56 P.M. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** BOM 20 F Yrs 220-16-2538 Director 73 July 10, 1926 Pennsylvania Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28e-f show other trsumstic event, the Heaton Examiner must be notified at Mineral Piedmo it 15 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 52 W. Harrison St. 26750 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status 2 should be filed within 72 hours after and Mental Hygiane. Is marked other than "natural", or ite Yes 2 No 45-47 if Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White λq Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Moran Trucking Truck Driver permit. Peges 1 and 2 should be file Department of Health and Mantal Hy Important: If them 27 is marked other eny Injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be James W. Fazenbaker Irma Marie Morgan 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Colleen Beeman / Spouse 52 W. Harrison St. Piedmont, WV 26750 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bloomington Cemetery 4/12/2000 Bloomington, MD 21. Signature of Funerel Service-Licenses 22. Name and Address of Facility 111 Church St. Boal Funeral Home Wester port, MD 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) E v amitter Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) and physician s the burial Box 68760 Physician/Medical Due to (or es e consequence of) 887 0.4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 2 signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à 2 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed page 2 1 Yes 2K No 1 ☐ Yes 2 ☐ No KESPIRAT Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Pis heral 28b. Time of 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Neturel 5 Pending investigation Injury 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) š 4 Homicide To the Hospital within 24 hours a To the Funeral C edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a, Certifier 296. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number 20800 April 2000 Name end address of person who completed cause of deeth (Item 23e) (Type, Print) obert Welik MD Seton 902 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture APR 13 2000 Registrar



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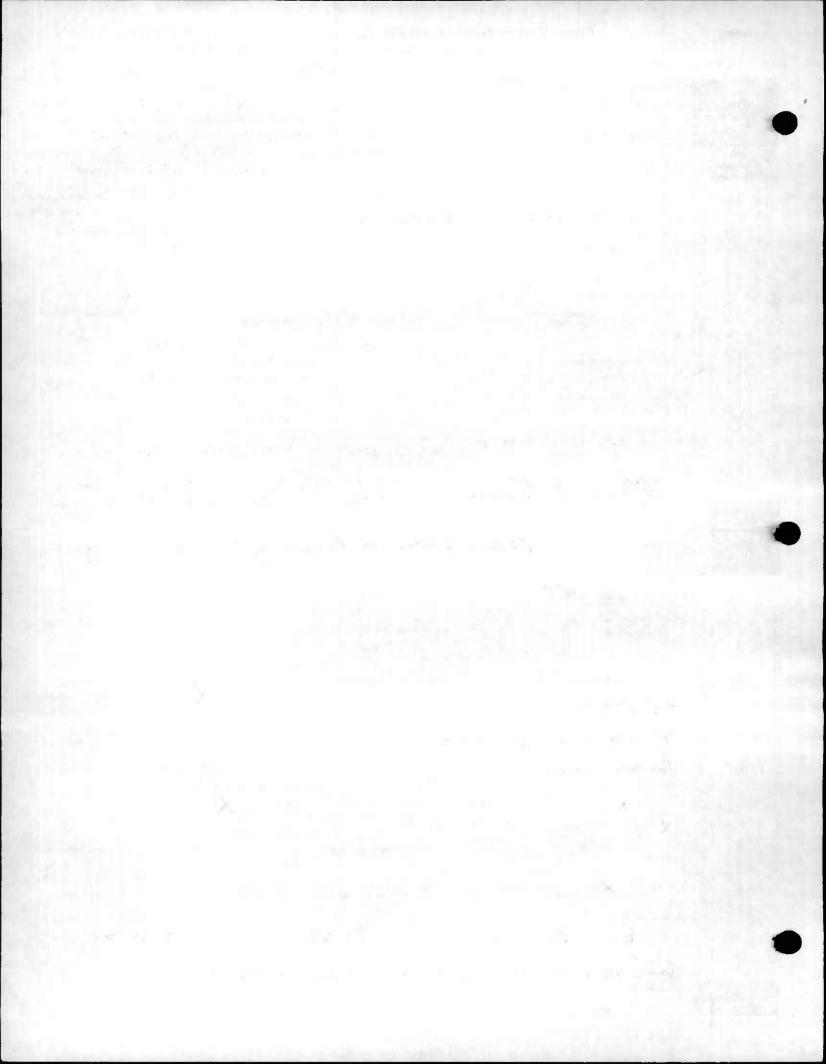
State of Maryland / Department of Health and Mental Hygien

Amended Item#10d perFHG785 7/25/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dey 2000 **Physician** Carl Eugene Martin Sr. April 28, 12:30 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 215 Summerset Road Stevensville Queen Anne's Hours Min. October 23, I 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** MM 20F Months Deys 577-18-9658 Yrs. Director 82 Washington DC 1917 Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryfar Dependent of Heelih and Mentel Hygiens. Important: If them 27 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Marylinal Examines man be notified as 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Queen Anne's Stevensville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 215 Summerset Road 21666 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 12 Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2€XNo Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Business Owner Retail 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Francis Joseph Martin Annie Margrett Mitchell 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Calvin Martin/Son 215 Summerset Rd. Stevensville, MD 21666 20a. Method of Disposition 20b. Piece of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, Stete 1 ☐ Burial 2XX remetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center April 29, 2000 Chester, MD 21. Signeture of Funeral Service Licanses 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home 23a. Pert1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximete Intervel Between Onset and Death **Physician** Immediete Ceuse (Final diseese or condition resulting In death) . Chanic Obstruction Palmoney O'Brine /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner ettending physician end for use es the bunal-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events.) Due to (or es e consequence of): Records, P.O. Box 68760, The law requires that the death certificate be thet initieted events resulting in death) Lest Due to (or es e consequenca of) Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Serve triungia regargitation certificate has Prostete cencer 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

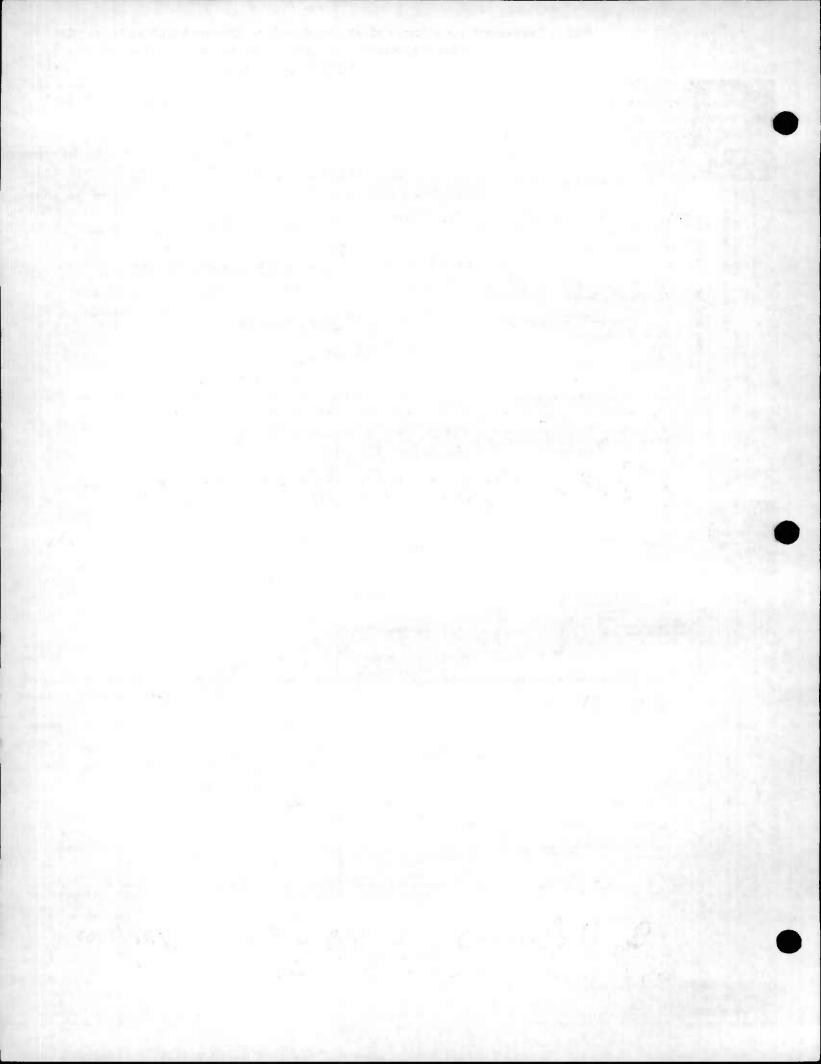
Injury et 28d. Describe how injury occurred 1 Yes 2 No edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner steted. 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 4-28-00 11339 30. Name and indiress of person who completed cause of deeth (item 23e) (Type, Print) JAMIE HALMS MO STEVENSVILLE MO 21666 130 Love Point LO 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar Genera



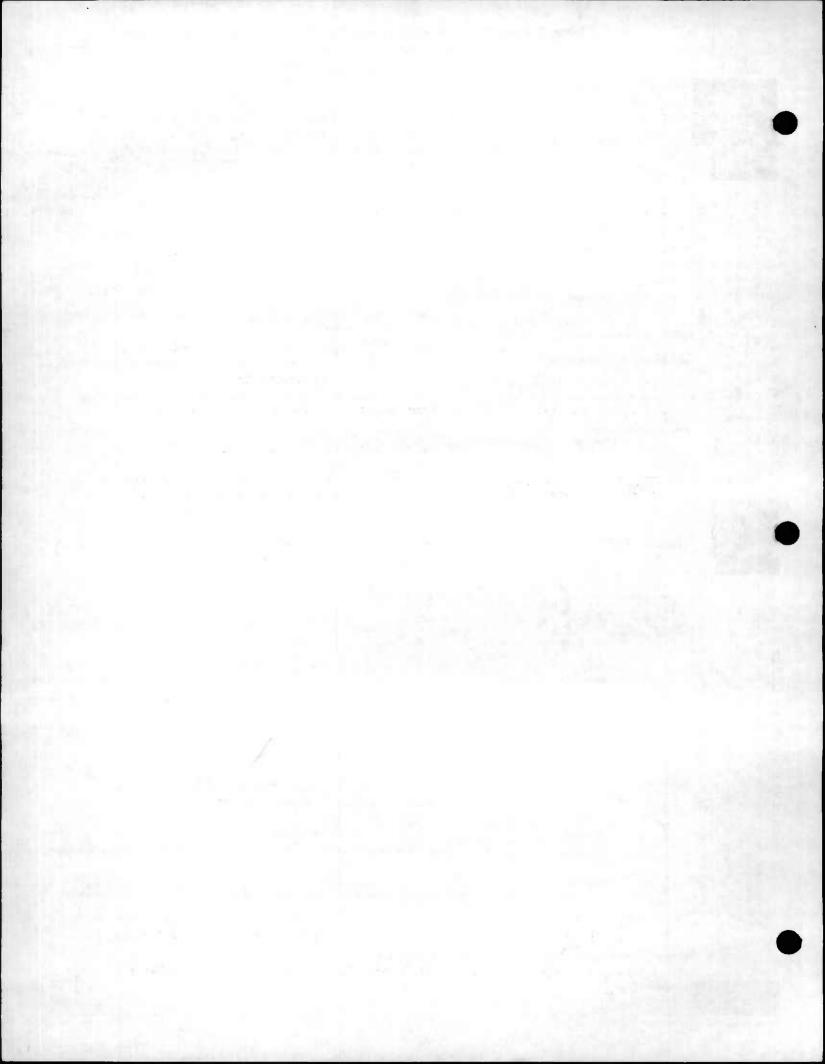
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Health a sem 27 is other tre		Judy Peppel/ Daugh	ter		802 W	orch	este	r Dr.	Stev	evensville, MD 21666			5
nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐	Removal from S		Place of Dispos cemetery, crem Sapeake	atory or	other pla	ce)		Date		on - City or To	
. 문문은		4 □ Donation 5 □ Other (Specification 21. Signeture of Funeral Service Licer			22.	Name e	nd Addre	ss of Facility	,				sville, MI
Depe Impo any ir		23a. Parti. Inter the disease, or com	1. Mac	um	Fe 10	11ow 6 Sh	s, H amro	elfent ck Rd.	oein Che	& Newr	MD 216		Home
hysician /Medical xaminer	er	shock, or heart failura. List only Immediate Cause (Final disease or condition rasulting in daath)	a		Cardi or as a consequ		nys	spoll	my				Interval Betwean Onset and Daath
physician and as the buriet-transit	Examiner	Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury	b. ———	Due to (or as a consequence of): Due to (or as a consequence of):						23h Plid to hacco use contribute to the cause			
CD est	Medical	Cause (Disease or injury that initiated events resulting in death) Lest	d										
e ettending	Cial	Don't II. Other sloudflood as addition											
ed by th	by Physician/M	Part II. Other algnificant conditions of	entributing to dea	tributing to death but not resulting In the underlying cause given In Part I.						23b. Did tobacco use contributa to the cause 1 Yes 2 No 3 Probably 4			
s been s 2 should	Completed									24a. Was perfo	an autopsy ormed?	av	ara autopsy findings vailable prior to empletion of cause daath?
pa	Con									10	Yes 20No	1[☐ Yes 2☐ No
s certificate director, pag	Be	25. Was case refarred to medical axaminer?							of Daath	(Check only	one)		
this certific	P	1 ☐ Yas 2 🖹 No								me 5 Residance 6 Other (Specify)			fy)
After fune	ıtlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		f Injury , Day Year)	28b. Time of Injury	м	28c. Injur Wor 1 □	yat k? Yes 2 □ N		8d. Describe	how Injury oc	curred	
무슨	Certification:	3 Sulcide 6 Could not be detarmined	28e. Place	28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)			ry, office	28f. Location (Street and Number or Rural City or Town, Stata)		al Routa Number,			
24 hours Funeral letely filled	edical	29a. Certifiar Cartifying Ph (Check only one)	Iner: On the bas	sis of examina	owledge, daath ation end/or Inve	occurrece estigation	at the tir	ne, date and pinion, death	placa, a occurre	nd due to the	cause(s) and date and plac	mannar as s ce, end due t	stated. o the cause(s)
within 2 To the comple	Me	29b. Signature and title of certifier	and mann	o sidleu.		29	c. Licens	e number	-		29d. Date sig	ned (Month	Dav. Year)
3 ⊢ 8		1010	ne	->					386				
		30. Name and address of person who	completed cause	of death (Iter	- 1 6	rint)	Pro	a C	المحا	er, M.	5 216	19	
0.	te	31. Data filed (Month, Day, Year)	32. Re	gistrár's Signa	ature					-			



DHMH 16 Rev 6/95

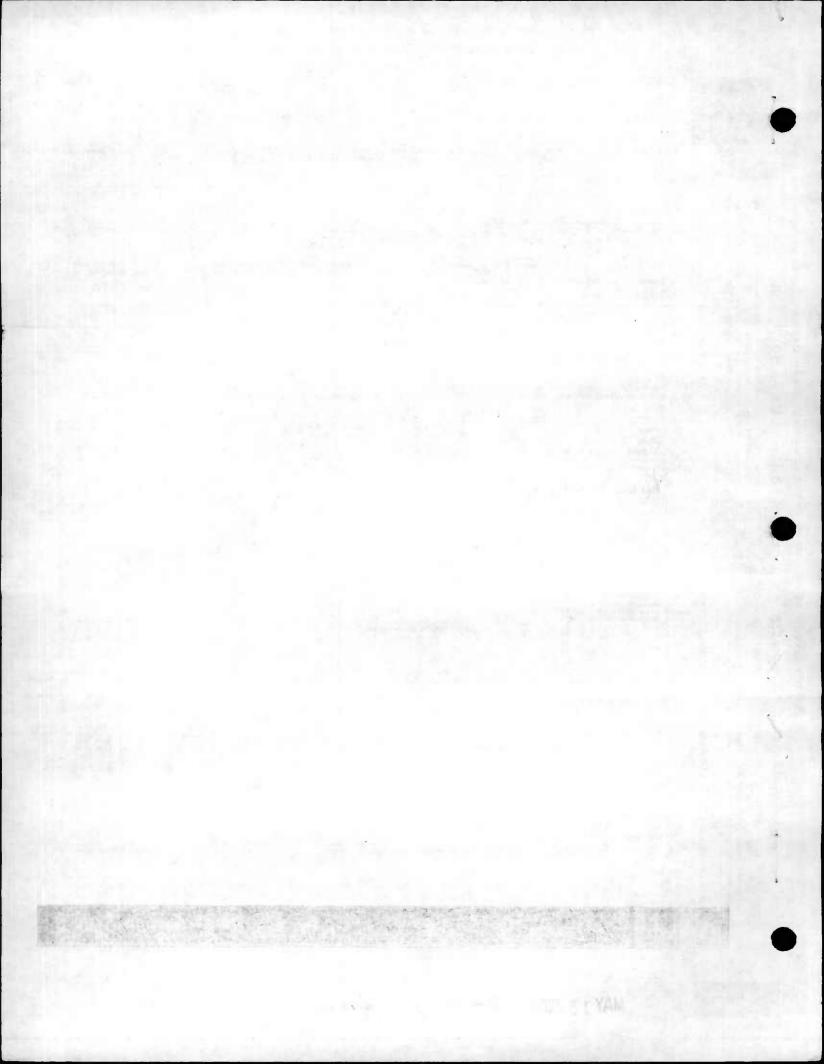
Registrar

MAY 1 5 2000

9:10 p.m.

2000

Barbara Tarbert



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amend item 24a per phys. verbal response 5/16/00

G783 yg

Certificate of Department 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** MILTON ALLEN MAY 2000 /Medical 1:15 PM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland of Hyattsville Hyattsville If Under 24 Hrs. 8. Da Hours Min. (M Prince Georges

9. Birthplace (Slete or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) If Under 1 Year **Funeral** Days Months 1X M 2□ F 49 Director 402-36-4816 Sept 23, unk Usual Residence of Decedent 10b. County Prince Georges 10a State 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Hyattsville Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a 5600 Riggs Road Funeral 20783 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 kd Yes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: à Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk military federal govt other permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: If flem 27 is merked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be unk unk 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Heartland of Hyattsville 5600 Riggs Rd Hyattsville, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Fundal Service Ucensee Adde, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting In death) /Medical CARCINOMA LUNG with Brain Metastases Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and sthe burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Due to (or es e consequença of) USe as ò been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evalleble prior to completion of cause Completed 24e. Wes en eutopsy performed? page 2 s has certificate 1 ☐ Yes 2 TrNo 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours effer death. Euneral Director: After this certificately filled in by the funeral director; Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Atterwithin 24 hours effer dea To the Funeral Director completely filled in by th 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. (Check only one) 29b. Signeture end title of cartifier License number 29d. Date signed (Month, Dey, Year) ORE, MD 4203 QUEENSBURY Ad HY ATTSVILLE MID 2018

State Registrar AUC

31. Dete filed (Month, Dey, Year)

MAY 1 6 2000

32. Registrar's Signeture

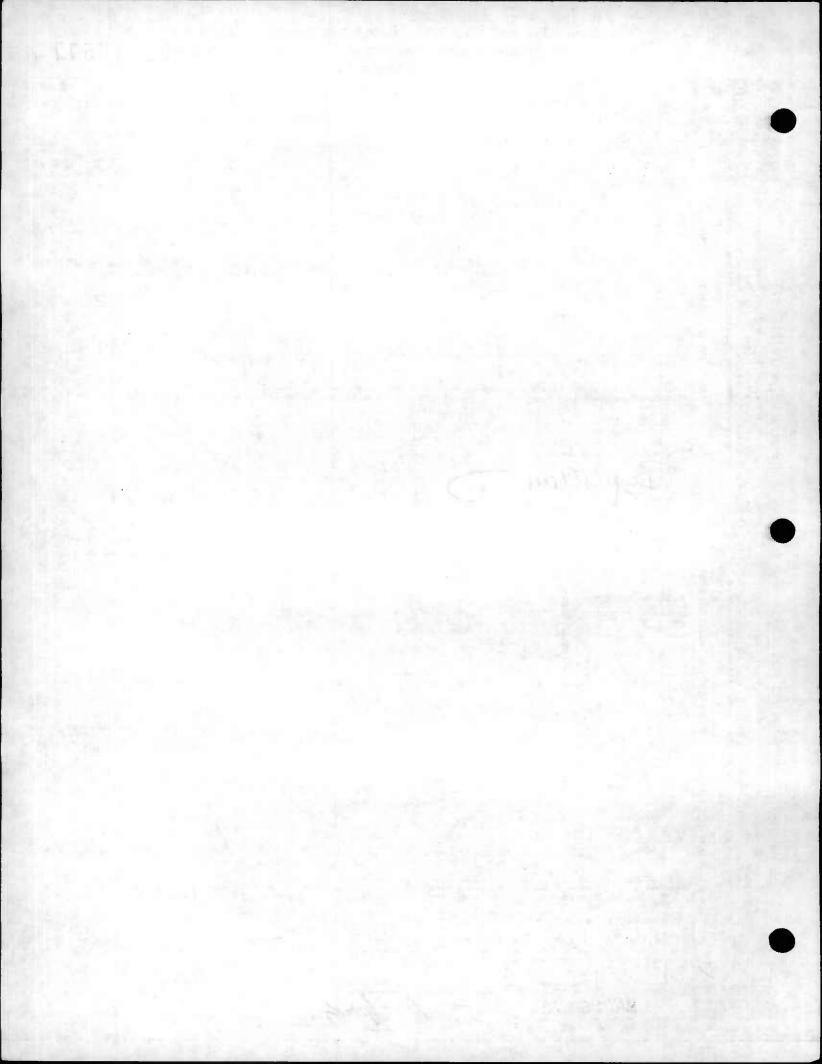
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	Pauline Armacost					05	14 2000		
						City, Town, or Location of Death 4c. County of Death			
Broadmead Retirement Community Cock 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under						s. 8. Dete of Bir		D. Birthplace (Stete or Foreig Country)	
218-22-	4321	1 M 2 F	94	Yrs. Months	Deys Hours Mi	May 5		Maryland	
suel Residence d	of Decedent		100 City To	m as I costion					
MD	10b. County	100		wn or Location				10d. Inside City Limit	
0e. Street and Nu		Baltimore Cockeys			a da		10g. Citizen of Who	^	
		d., Apt.	M-1				USA	et Country?	
 Meritel Stetus Never Men Widowed 	ried 2 Merried	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Yeer or Deter	s? ☑ No	13. Wes Deceder If Yes, specify	nt of Hispenic Origin? Cuben, Mexicen, Pu	(Specify Yes or No erto Rican, etc.)		American Indien, White, etc. White	
/Sno	15. Decedent's E	Education	16	Decedent's Usuel (Occupation	rodkina	16b. Kind of Busin		
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	(First, Middle, Last						, Maiden Surneme)		
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-	5 Other (Speci	Money	Jess	ops Cemete	Address of Fecility	5/17/00	Sparks,	, Maryland	
Brya	perolle	out		Lemmon	Funeral Ho Padonia Ros		rium, MD	21093	
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M	Ulti.	-infor	et:	Demer	tio		s en eutopsy ormed?	24b. Were eutopsy findings evailable prior to completion of ceuse of deeth?	
						10	Yes 2000	1 Yes 2 No	
25. Wes case refe	rred to medical				26. Plece of D	eeth (Check only			
exeminer?	No	Hospital:	atient 2 ER/C	outpetient 3 DOA	Other:		idence 6 □Other	(Specify)	
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2 Accident	Investigetion								
2 Accident 3 Suicide 4 Homicide	6 Could not to	be 28e. Plece of	Injury - At home, t etc. (Specify)	erm, street, fectory,	office		(Street end Number wn, Stete)	or Hure! House Number,	
3 Suicide	6 Could not be determined	28e. Plece of building,	etc. (Specify) st of my knowledg	erm, street, fectory,	office the time, date end pla n my opinion, deeth oc	City or To	wn, Stete)	ner es stated.	
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Th

	1. Decedent's Ne	me (First, Mic	ddle, Last)							2	. Date of Dec		Yeer	3. Time of Deeth
hysician /Medical		Theresa Lynn Ashline							May	Dey 07	2000	9:50 A.M.		
xaminer	4e Facility Name								4b. City, Towr				y of Deeth	
		4425 North Point Boulevard					. Klied		Sparrov				imore	
neral ector	5. Social Security	3289	6. Sex	M 2□xF	'. Age (In yrs	. last birthd Yrs	Months	er 1 Year Deys	If Under 24	Min.	Dete of Birt (Month, De) Aug. 1	h y. <i>Year)</i> L1,1958	9. Birth Cou Mar	place (State or Foreign ntry) 'yland
	Usuel Residence 10a. Stete	10b. Coun	nty		10c. C	ity, Town or	r Location							10d. Inside City Limits
ector										1 ☐ Yes 2 🖔				
Director	10e. Street and N			10f. Zip Code				de			10g. Citizen of Whet Country?			
<u>a</u>	7825 #	119 Lo	dge F	arm Ro	ad			21	219		- 11	United	l Stat	tes
by Funeral	11. Marital Status 1 ☐ Never Me 3 ☐ Widowed	orried 24∑ M 1 4 □ Divorc	arried	Armed Ford 1 Yes 2 If Yes, Give Yeer or Dat	ces? 2⊠No	U,S. 1			Hispanic Originan, Mexican, I Specify:	r? (Speci Puerto Ri	fy Yes or No- can, etc.)	- 14. Ra Bi	eck, White,	can Indien, , etc. nite
	15. Decedent's Ed (Specify only highest great			tion		16e. De	6e. Decedent's Usual Occupation (Give kind of work done during most of workife. DO NOT use retired)			4	16b. Kind of		Business/Industry	
Completed	Elementary/Se			College (1-	4or 5+)	(G lif	e. DO NOT	use retire	durring most o	working				
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Be	17. Father's Nem										Maiden Suma 11iams	me)		
	19a, Informant's				· ~)	19b. M	eiling Addres	ss (Stree	end Number	or Rural I	Route Numbe	er, City or Town	n, State, Zij	p Code)
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any injury pace.	21. Signature of	Am	100	Ahr	Va.	1	Duda	-Ruc	ess of Fecility k Fune:	al F	lome of	f Dunda	1k, I	inc.
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State Registrar

od (Month, Dey, Year) 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) MAY 1 6 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. PATRICIA BUSH State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 727 28A-F PER MEOCertificate of Death ASP 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month Dey **Physician** MAY 11 2000 2130 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BON SECOURS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Sociel Sacurity Number 7. Age (In yrs. lest birthdey) 9 Birthplece (State or Foreigh **Funeral** 1□M 2 F Months Deys Hours 7-64 Yrs Director Usual Residence of Dacedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Director Maryland 10g. Citizen of What Country? 10a Street and Number 10f Zin Code Funeral 12. Was Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mentel Hygiene. 1 Nevar Married 2 Merried 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0020 1□ Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Speondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumema) Eathar's Neme (First, Middle, Last) Be 6 2 Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City of Town, Stete, Zip Code) Ister permit. Peges 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra 2 Baltimore. 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Buriel 2 □ Cremetion 3 □ Ramovel from Stete 12000 4 □ Donetion 5 □ Other (Specify) emete ture of Funeral Servica Libensae 22. Name end Addrass of Facility PI 21216 . Nor AUR th 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock or heart fellips. List only one ceuse on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel HYPOXIC ENCEPHALOPATHY disease or condition resulting in deeth) Examiner Due to (or as e consequence of) Examiner DUE TO CARDIO-RESPIRATORY ARREST ician end bunal-transit the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) DUE TO NARCOTIC INTOXICATION Box 68760 Physician/Medical Due to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were eutopsy findings avelleble prior to completion of causa of deeth? Completed 24a. Wes an autopsy The law Yes 15 Tes 2□ No 2 No of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) edicai Certification: To XXYes 2□ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) FOUND: 5-8-00 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Division or Attending 5 Pending investigation 1 Netural UNKNOWNM deeth. 1 Yes 2XXNo UNKNOWN 2 Accident after deeth 6 X Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number City or Town, State) BON SECOURS HOS 28e. Pleca of Injury - At home, farm, straet, factory, office building, etc. (Specify) 3 4 T Homicide HOSPITAL filled in BALTIMORE, MDUNKNOWN within 24 hours a To the Hospital 1 Certifying Physician: To the best of pry knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examination of the cases of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner as stated. 29a. Certifier completely (Check only one) 29b. Signatura and title of certifian 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E MAY 12,2000 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 land 101 31. Dete filed (Month, Dey, Year) 32. Regietrer's Signeture State MAY 1 6 2000 Registrar

DHMH 16 Rev 6/95

MEN 18250 James D. Jones

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Lester A. Benway May 8 2000 11:30 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8110 West End Drive Orchard Beach Anne Arundel If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 1X M 2□ F 214 16 9063 Yrs. 79 April 16, 1921 Director Maryland Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c. City, Town or Location IOd. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Maryland Anne Arundel Orchard Beach 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 8110 West End Drive 21226 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. be filed within 72 hours efter de tal Hygiene. d other than "natural", or flam svant, the Medical Example of Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 21215-0020 1 Yes 2 No Specify: Specify: þ White 3R Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Md. Workshop For Elementary/Secondary (0-12) College (1-4or 5+) 9th Supervisor The Blind Maryland permit. Pages 1 and 2 should be file Department of Health end Mental Hy important: If item 27 is marked othn sny injury or other trauments svant. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur L. Benway Mary Nodine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Lambert / Daughter 8110 West End Drive Orchard Beach, Maryland 21226 Baltimore. 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park5/11/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ances Immediate Cause (Final disease or condition resulting in deeth) /Medical ean Examiner Physiclan/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events P.O. Box 68760 that initiated events resulting in death) Last the th to (or as a consequence of): for use as been signed by the e should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Daath (Check only one) 1 Yes 2 No Other: 4 Nursing Home Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 Other (Specify) this 28a. Dete of Injury (Month, Dey Year) 27. Manner of De 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Natural 2 Accident 5 Pending after death. 1 TYes 2 □ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospitai 24 hours a Funerai D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. Medicai 29a. Certifier completely (Check only one) To the Vithin 2 29b. Signature and title of certifie 29c. License number

State Registrar

DHMH 16 Rev 6/95

11:00 - 2004

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31. Date filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Yaar Month 55 Gerard Henry Brocksmith Mar 8 10 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Harford Harford Memorial Hospital Bel Air If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Days 1XM 2□ F 213 09 4117 Vrs 85 April 1, 1915 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 426 Bon Air Road 21225 U.S. 14. Race - Amarican Indian 11, Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, atc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10th Foreman Bethlehem Steel 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nema (First, Middla, Last) Henry G. Brocksmith (not available) 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Catherine Brocksmith / wife 426 Bon Air Road Baltimore, Maryland 21225 20b. Place of Disposition (Nema of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from Stata 5/12/00 Lorraine Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signutification Funeral Service Licenses 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a Part1. Enter the disease, shock, or heart failura. L namerous not enter the mode of dying, such as cardiac or raspiratory arrast, Approximate Intervel Between Onsat and Daath ations that caused the de Immedieta Cause (Finel diseasa or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of causa of death? 20 No 1 Yes 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2P No Other: 4 ☐ Nursing Homa 5 ☐ Residence 8 ☐ Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 Yas 2 No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

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Physician/Medical Examiner à Completed 8 edical Certification: To after deati 8

Physician

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Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If hem 27 is marked other than "natural", or frama 23a or 's any injury or other traumatic event, the Medical Exemples mass be as

Physician /Medical

Examiner

Saltimore, Maryland 21215-0020

Director

Funeral

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State Registrar

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Way 31. Date filed (Month, Day, Year, 16

29b. Signatura and titla of certifier

4 Homicide

29a, Certifier (Check only one)

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32. Registrar's Signature

d causa of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

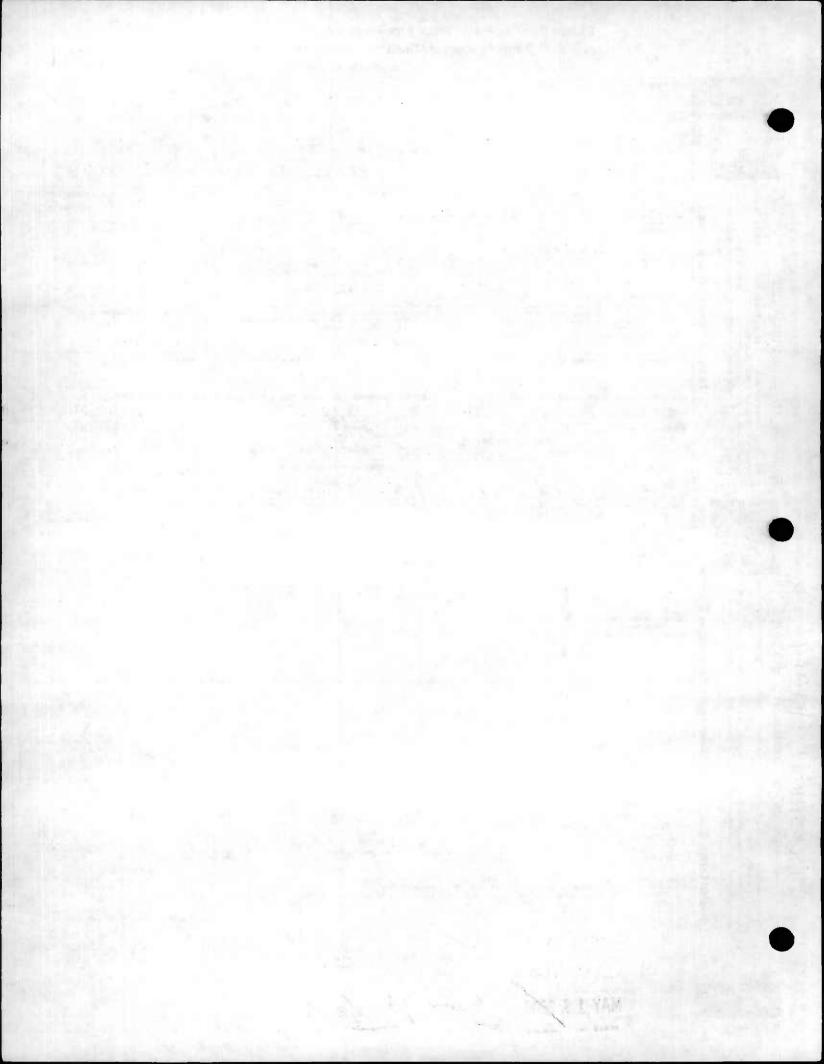
29c. License number

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29d. Date signed (Month, Day, Year) 8

2000

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death May Month 11Pey 2000ear 7:05 AM Rebecca R. Blevins 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Brooklandville Baltimore Genesis Brightwood | H Under 1 Year | H Under 24 Hrs. 8. Dete of Birth (Months, Days Hours Min. 8-26-1958 Birthpiace (Stata or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2□F 212-90-5016 41 Yrs Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Cockeysville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 9C Bridgelake Circle U. S. A. 21030 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, Whita, etc. 11. Merital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 X Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) В. Beck William E. June Rhoads 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) William E. Rhoads (father) 14116 Jarrettsville Pike Phoenix, MD. 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetary, cremetory or other placa) 20c. Location - City or Town, Stete Dete 1 Surial 2 ☐ Cremation 3 ☐ Removet from Steta 4 ☐ Donation 5 ☐ Other (Specify) St. John's Lutheran 05/14/2000 Sweet Air, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 23a. Pert1. Entar the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or es e consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 24 NO 26. Piaca of Deeth (Check only one)

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

25. Wes casa rafarred to medical examiner? 1 Yes 25 No 27. Manner of Deeth 1 Natural 2 Accident 5 Pending

3 Suicide

1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Other: Nursing Home 5 Rasidence 8 Othar (Specify) 28d. Describe how injury occurred

1 Yes 2 No

28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one)

Cortifying Physician: To the best of my knowledge, death occurred at the time, data end place, and dua to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et tha tima, date and placa, end due to the cause(s) end manner steted.

29b. Signature and title of certifie

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investigation 6 Could not be datermined

29c. License number

29d. Dale signed (Month, Day, Year)

281. Localion (Street end Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ME 30 0

32. Registrar's Signeture

State Registrar

Physician

/Medical

Examiner

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Funeral

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Hygiene. **natural*, or items 23e or 28e-f ent, the Medical Examiner must be notifi

marked other

permit. Pages 1 and 2 should be file Department of Health and Mental. Hy Important: If Item 27 is marked oths any injury or other traumatic event.

Physician

/Medical Examiner

attending physician and if for use as the burial-transit

signed by t d be detach

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

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Completed

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Certification: To

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The law requires that the death certificate

Records, P.O. Box 68760,

Division of Vitai

laltimore, Maryland 21215-0020

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filed (Month, Day, Year)

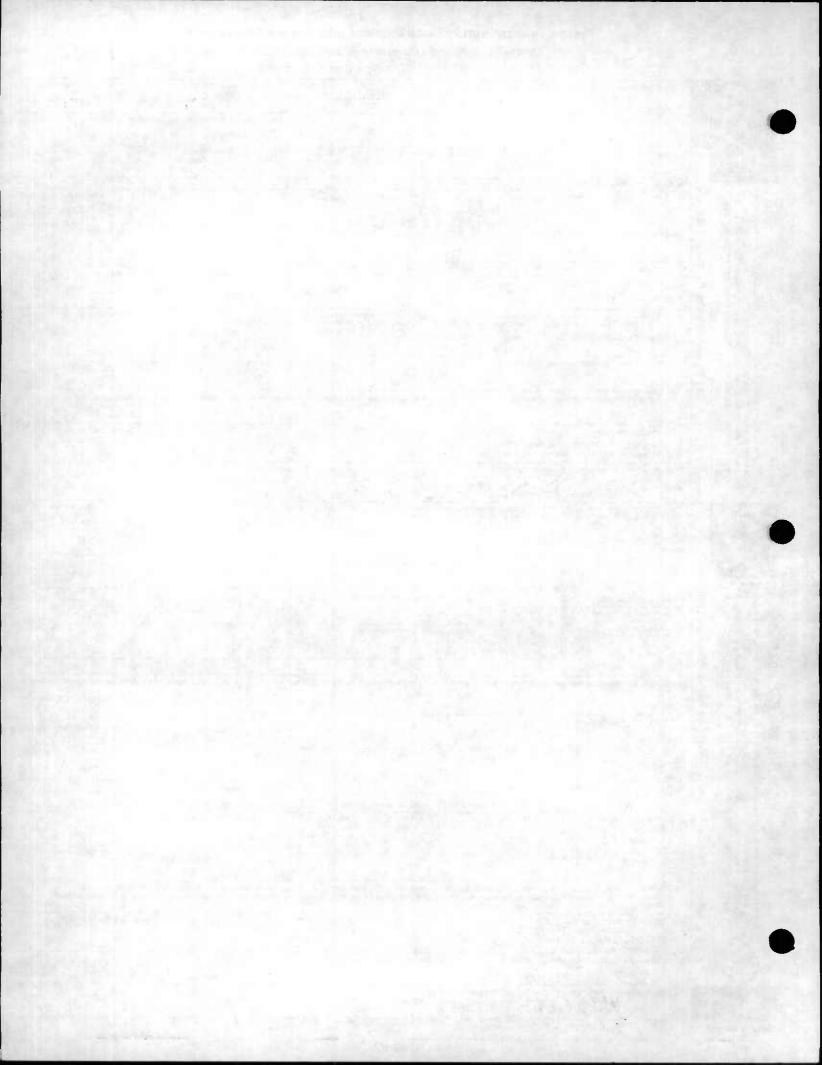
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And Sept		- Waryiana /	Certificate of			eg. No.	3. Time of Death	
Physician	Decedent's Neme (First, Middle, Last) Ann	na Marie	Barrett		Month May 11	Dev Yee		
/Medical Examiner	4a Facility Neme (If not institution, give street and no	mber)		4b. City, Town, or Lo		4c. County of De	ath	
	Stella Maris			Timonium		Baltimore		
Funeral Director	5. Sociel Security Number 215-12-9070 Usual Residence of Decedent	7. Age (In yrs. last to 82	birthdey) If Under 1 Yeer Months Days	Hours Min.	8. Dete of Birth (Month, Dey, Dec. 10	Year) 9. B	irthplece (State or Foreign Country) Md.	
Varyland f show	10a. Stete 10b. County		wn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
the N	Md. Baltimore 10e. Street and Number	1.	imonium 101. Zip Code		1	0g. Citizen of What (Country?	
23a or	2300 Dulaney Valley Rd.		2109	93		USA		
ges 1 and 2 should be filed within 72 hours eiter death with the Maryland it of Haalih and Menleit Hygiene. If of Haalih and Menleit Hygiene. If of Haalih and Menleit Hash "natural", or items 23a or 28a-f show or other traumatic event, the Masinal Examination in contradiction. To Be Completed by Funeral Director.	Armed F	2 🖾 No ive	13. Was Decedent of a tf Yes, specify Cub 1 ☐ Yes 2 ☑ No		cify Yes or No- Ricen, etc.)	Specify:	nericen Indien, nite, etc. White	
d 2 should be filed within 72 hours eff this and Mantel Hygiens is it is marked other than "natural", or treumatic event, the Mantel Exam. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College	(1-4or 5+)	Ga. Decedent's Usuat Occu (Give kind of work done life. DO NOT use retire Home maker	ation during most of working f)		16b. Kind of Busines		
Hygic Hygic Co	17. Fether's Neme (First, Middle, Last)		Tome maker	18. Mother's Name	(First, Middle, I		=	
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2 shou and M le meri	19a. Informent's Neme/Reletionship (Type, Print)	15	9b. Mailing Address (Stree	end Number or Rura	I Route Number	City or Town, Stete	, Zip Code)	
and 2 sauth ar n 27 is ner trau	Mr. William J. Barrett/s	on :	10514 Gateri	dge Rd. Co	ckeysvi	lle, Md. 2	21030	
7 4 9 2	20e. Method of Disposition 1 A Burlal 2 Cremetion 3 Removel from 4 Donetion 5 Other (Specify)	Stete cemei	of Disposition (Name of tery, crematory or other ple ed Heart of	Jesus 5	/15/00	Dundalk,		
permit. Pe Departmen Important: any injury ong.	21. Signature of Funeral Service Industrial	20	22. Name and Addr Ruck Tov 1050 York	ess of Fecility WSON Funer Rd. Towso	al Home	, Inc. 21204		
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olan: artifica ector,	25. Wes case referred to medicel examiner?			26. Place of Death	(Check only or	е)		
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To the Hoeptal or Attending Physician: The lew within 24 hours after deeth. To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	2 Accident investigation	oth, Day Year)		Yes 2 No		ow injury occurred	Rural Route Number,	
rs after al Directif	determined 200. Flet	ling, etc. (Specify)	ferm, street, fectory, office		City or Town		riurai rigulo riumbar,	
To the Hospital of within 24 hours a To the Funeral D completely filled in Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the land mei	e best of my knowled pasts of examinetion of their steted.	ge, deeth occurred et the tr end/or investigation, in my	ime, date end plece, e opinion, death occurr	end due to the c ed at the time, d	euse(s) and manner ate end place, and c	as stated. lue to the cause(s)	
withir comp	29b. Signeture and title of certifier	311-5-1-	29c. Licen			9d. Dete signed (Mo	onth, Dey, Year)	
(Chilitial !	7.7	\$	13283		5/121	00	
4	30. Name and address of person who completed cau		(Type, Print)	13283 ne Mo	dia	230		
State Registrar		Registrer's Signature	& Spor	6				

1×1×10 -



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Deeth STUART C. BARDOFF MAY 13, 2000 12:40 PM 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 4701 PARKFIELD COURT BALTIMORE BALTIMORE If Under 1 Year If Undar 24 Hrs. Months Deys Hours Min. Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Months 1**X** M 2□ F 213-16-9024 78 JUNE 2, 1921 MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e Street and Number 10a. Citizen of Whet Country? 10f. Zip Code 4701 PARKFIELD COURT 21208 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Merital Status Black White etc. 1 D Yes 2 No If Yes, Give Year or Detes: 1 Nevar Married 2 Married 1 Yes 2 No Specify: WHITE Specify: 3 ₩ Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALES AGENT AUTOMOTIVE 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surneme) **ABRAHAM** BARDOFF KATHERINE SELIGER 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) SAMUEL BARDOFF / SON 3919 ESGARTH WAY - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5 ☐ Other (Specify) (ANSHE EMUNAH) AITZ CHAIM 5/15/00 BALTIMORE, MD 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, on each line. Approximate Interval Between Onset end Deeth Immediete Cause (Finel diseese or condition rasulting in death) Acuto ACUTE MYOCARNIAL INFARCTION 11 Ascun LOYKS Due to (or es e consequence of): Due to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evalleble prior to completion of causa of deeth?

1 Yes 2 No

29d. Date signed (Month, Dey, Year)

2///>

14/60

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

MD

Funeral

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

"natural"

other than

the Merylend

filed within 72 hours efter

Pages 1 and 2 should be nent of Health end Mentel Department of Health end Mentel Important: If Itam 27 is marked on any Injury or other traumatic av

altimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital

thet the death certificete be

Examine ettending physician end for use as the bunel-transit edical Physician/M þ Completed Be 2 Certification:

certificate?

After this

if or Attending P s efter deeth. f Director: After i

To the Hospital within 24 hours of To the Funeref E Hospital

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29e. Certifier

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24e. Wes en eutopsy parlormed? 1 Yes 200 No 25. Wes case referred to medical 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Dey Year) 27. Menner of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 | Homicide

State Registrar

-DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year) MAY 1 6 2000

29b. Signeture and title of certifier

CKU SJKUADI

ALVE owin 61 32. Registrer's Signeture oaks

Mun

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print)

ORIGINAL

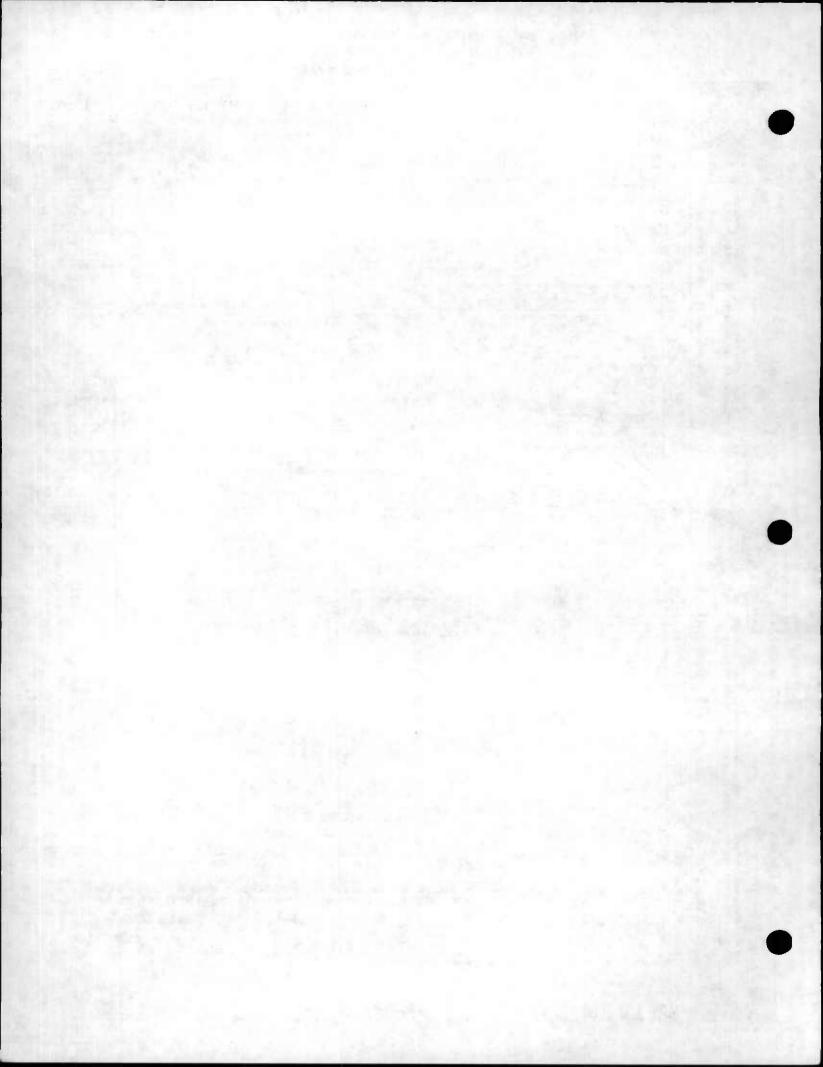
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1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

MILLE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 1400 Konera 12,2000 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Dath 4c. County of Death Crofton Covalescent Center Crofton Anne Arundel 8. Date of Birth (Month, Day, Year) AUG 23, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) Ohlo 1□ M 2EF Months Days Hours 82 579-70-7042 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Crofton Anne Arundel 1 Yas 2 No 10e. Street and Number 2131 Davidsonville Road 10f. Zip Code 21114 10g. Citizan ot What Country? USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 22 No if Yes, Giva Year or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-it Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Seamstress Self-employed 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Malden Surneme) Unk. Jennie Mae King 19e. tntormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Wisekal/daughter 1776 Farmington Ct., Crofton, MD 21114 20b. Placa of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 🏻 Cremation 3 ☐ Ramoval trom State Metro Crematory, Inc. 5/13/00 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licenses Cremation Society of Maryland, Inc. Inomos Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD 4 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated avents Due to (or as a consequence of): Dua to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco usa contributa to the cause of death? 1 Yss 2 No 3. Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an eutopsy performed' 1 Yes 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 1 Netural 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suiclda 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be executed DivIslon of Vital Records, P.O. Box 68760,

burial-transi attending physician for use es the buria signed I certificata hes b director, After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Physician

/Medical

Examiner

Funeral

Director

28a-f ehov

Director

Funeral

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Completed

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Physician/Medical Examiner

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Completed

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Medical Certification: To

4 I Homicide

29b. Signature and titla of certifier

29a. Certifian

ed other than "naturel", or items 23s or 28s-f sho avent, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death with 1 Department of Health and Meniel Hyglena. Important: If filem 27 is marked other than "naturef", or items 23s or 2 any fullury or other traumatic avent, the Medical and 1000.

Physician /Medical

Examiner

State

Registrar

30 Name and addrass of person who complated cause of death (Item 23a) (Type, Print)
Howardk Schultz Jr., 1439 De Ken 2000 32. Registrar's Signar

29c. License number

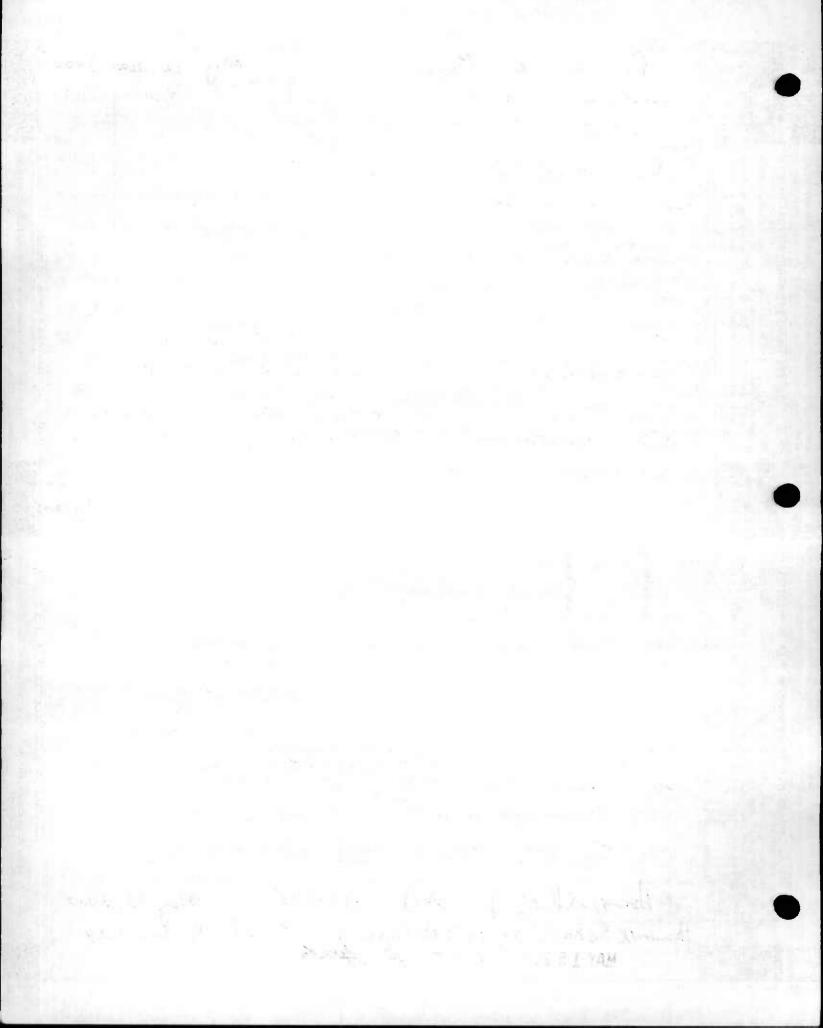
1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Piaca of Injury - At home, farm, street, tactory, offica building, etc. (Specify)

29d. Date signed (Month, Day, Year)

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DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2 Date of Death MAY 13, **Physician** 2000 Frederick Dewey Bennett 2:57 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
JUNE 2, 1917 Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 10 M 20 F 098-16-1879 82 Yrs Montana Director **Usual Residence of Decedent** 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas X No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Fox Road 238 21078 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Physicist Dept. of Army permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if them 27 is marked other
any Injury or other transmersed other 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Leonard Parker Bennett Margaret Dewey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ellen B. Becker/daughter 21 Wilbur St., Albany, NY 12202 Baltimore. 20b. Place of Disposition (Nama of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 5/15/00 Baltimore, MD 22 Nama and Addrass of Facility
Cremation Society of Maryland, Inc. 21. Signature of Funaral Service Licensee Thomas cregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on sech line. Approximata Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Burchets Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the buria Due to (or as a consequence of) P.O. Box cata has been signed by the a page 2 should be detached to Part It. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to completion of causa of deeth? 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yas 2 No certificata Division of Vital or Attending Physician: funaral director. 25. Was case refarred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 hpatient Certification: To 2 ER/Outpatient 3 DOA 1□ Yes 2□ No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Naturat 5 Pending 1 □ Yas 2 □ No death. investigation To the Hospital or Attendi within 24 hours after death To the Funeral Diractor; A completely filled in by tha f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tiple of confile 29c. License number 29d. Date signed (Nonth, DayAYear) ss of person who of of death (Item 23a) (Type, Print) Anthony HARFORD MEMORIAL HOSPITAL 32. Registrar's Signature State 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day 2000 MAY Month **Physician** Donald Seth Baker 11, 11:25 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day Year) APR 5, 1968 5. Social Security Number 9. Birthplace (Stata or Foreign Florida 7. Age (In yrs. last birthday) **Funeral** X□M 2□F Hours 266-35-6663 32 Yrs. Director Usuai Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Howard Columbia 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 11265A Skilift Court Columbia USA Herrie 23a Funeral 12. Was Decedant Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 1991 filed within 72 hours after Nevar Married 2 Married 1 Yas 2 No Saltimore, Maryland 21215-0020 natural, or Specify: 1994 Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) 1 2 Collega (1-4or 5+) X-Ray Techician U.S. Army 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Pages 1 and 2 should be 1 sent of Health and Mental 1 nt: If Nem 27 is marked of Alice Ludden Earl Baker 19a. Informant's Name/Ralatlonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Timothy Johnson/Executor 9534 Many Mile Mews, Columbia, MD 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Department of Important: If It any injury or 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 5/12/00 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 21. Signature of Ferieral Service Licenses Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar tha disaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting In daath) /Medical ane 3 mus Examiner Physician/Medical Examiner physicien end s the burial-transit Sequantially list conditions, if any, laading to immediata causa. Entar Undartying Causa (Disaasa or Injury that in its and as a critical causa or Injury that initiated avants rasulting in death) Last to (or as a consequence of): May 11, 2000 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown signed t à Be Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? pege 2 Baker, 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: director, 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas CZENO Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify Nus) Medical Certification: To this 28a. Data of injury (Month, Day Year) 27. Magnar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury Naturai 5 Panding death. 1 Yas 2 No invastigation 2 Accident after deati 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital
 24 hours a To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the time. 29a. Certifiar (Check only one) aminer: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign 29c. License number 29d. Data signed (Month, Day, Year) nd address of p who complated causa of daath/(Itam 23a) (Type, Print) BAUTIMOREM Hoday Nillaus 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State

Ö

Donald

Registrar **DHMH 16 Rev 6/95**

MAY 1 5 2000

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5588 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month May O7 **Physician** Charles Bell 2000 04:04 P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Hopkins Hospital Baltimore If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days Months 17 M 2 □ F 237-50-2287 Director N.C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow ! 10d, foside City Limits r than "natural", or items 23s or 28s-f ahor N/A 1X Yes 2 □ No Baltimore Directo Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1616 North Bradford Street U.S.A. 21213 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter ment of Health and Mentel Hygiens. ant: If item 27 is marked other than "natural; or ite ury or other traumatic event, the Mentel Examina Lry or other traumatic event, the Mentel Examina 1 ☐ Yes X☐ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify:Black þ 3 Widowed 4 Divorced Yeer or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Steel Work 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Lenora Everett Theodore Bell 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Annie Bell- wife 21213 1616 N. Bradford St. Balto. Md. 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Dete emetery, cremetory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 5-16-2000 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park Maryland 22. Name and Address of Fecility 639 N. Broadway Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter he mode of dying, such as cardiac or respiratory errest, List only one cause on each line. **Physician** /Medical Immediate Cause (Final Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner sicien end burial-trensit The lew requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initioled events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical phys. Due to (or as a consequence of) 98 for use signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Records, P.O. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? page 2 should hes 1 Yes 2 XNo 1 Yes 2000 of Vital Physician: 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1X Yes 2 No 1 ☐ Inpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation s efter deeth. 1 Yes 2 No 2 Accident the 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral C completely filled Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. May 8, 2000 30. Name and address of person who complete Jack M. Titus, M.D. erson who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAY 1 5 2000

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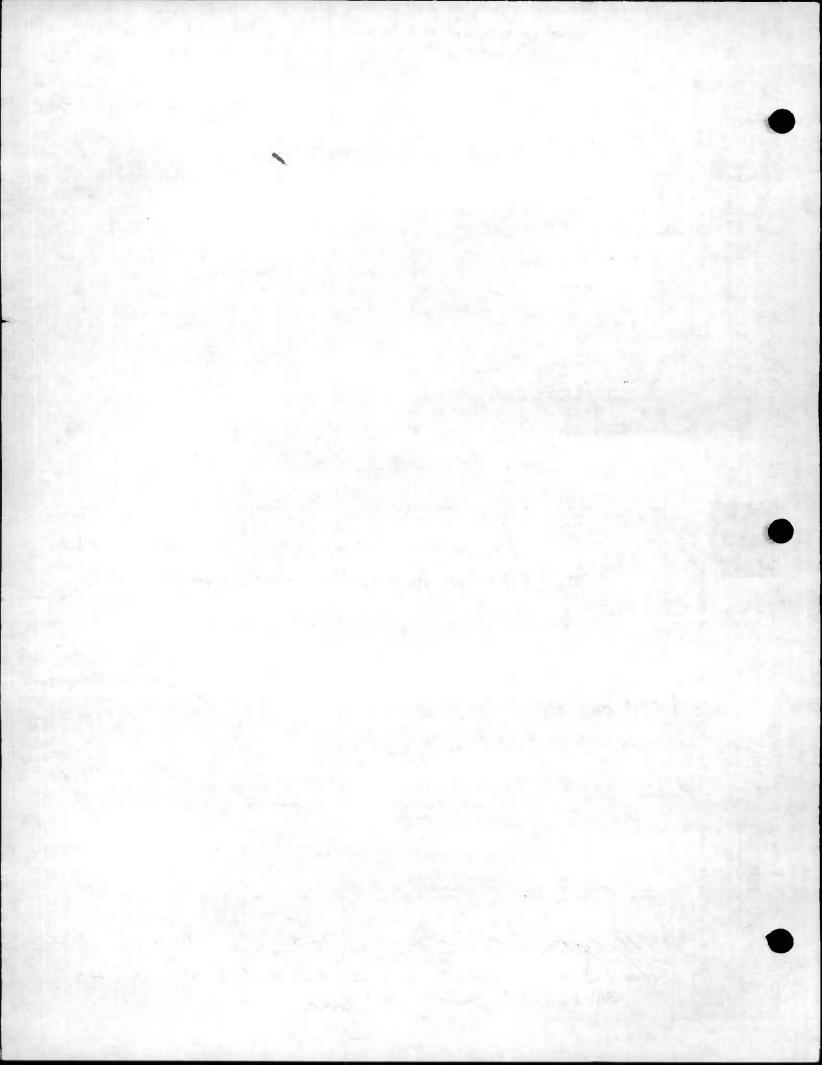
State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LOIS FAYE BELL 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) **Examiner** Cambridge Genesis Eldercare-Chesapeake Dorchester If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 2\ F 220-32-8917 Director Oct 16,1936 unk Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD Dorchester Cambridge 1 Yes 2 No Director 288-1 96 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 118 Sandy Hill Road Funeral 21613 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Deemit. Pages 1 and 2 should be filed within 72 hours after dead Department of Health and Mental Hygiene. Important if Item 27 is marked other the enty Injury or other trausments. Marra Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white by 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none key punch operator unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wheatley Cook Helen Bell 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Bell/son 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation _5 ☐ Other (Specify) Royald S. Wade, Director 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Well 21201 Baltimore, MD entl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heeft fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Medical Certification: To Be Completed by Physician/Medical Due to (or as a consequence of): be detached for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 2 2 No 3 Probably 4 Unknown of Vital Records, 24b. Were autopay findings aveileble prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) 1□ Yes 3ENo Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) nours after death.

neral Director: After this y filled in by the funeral di this 27. Manner of Death
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2 Accident 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division or Attending 5 Pending Investigation 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Di Decartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number se of death (Item 23a) (Type, Print) MD 31. Date filed (Mont MAY) 32. Registrar's Signature

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State Registrar



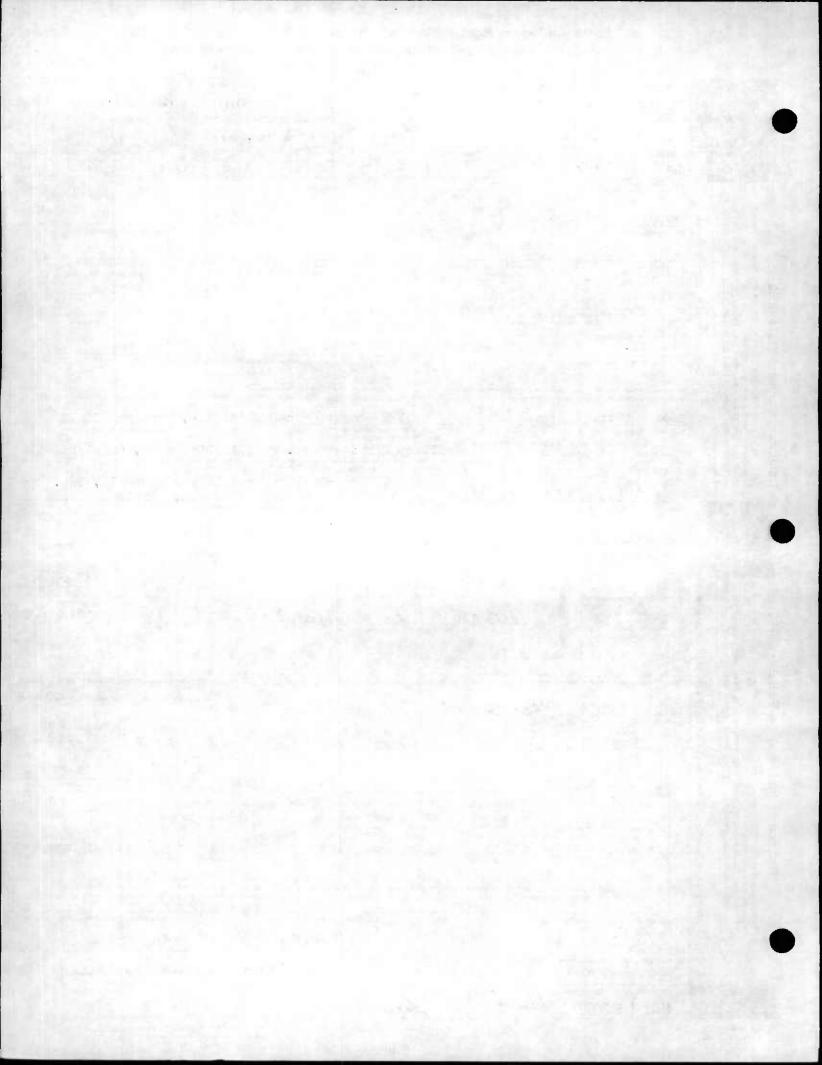
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** may 8:00 am Ellen Carrick 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Johns Hopkins Buy view Trans Frond Care Unit Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year, If Under 1 Yaar Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months Days 1 M 2 F 219-22-5446 Director 08 17 Maryland Usual Residence of Decedent works ! 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itel Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Mexical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code United States Funeral 2722 Moorgate Road 21222 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yaa or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Naver Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2€No Specify: Specify.White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 yrs. College (1-4or 5+) Home Maker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Peges 1 and 2 should be file.
Department of Health and Mentel Hy Important: if Nem 27 is marked oth any Injury or other traumatic eventees. Be 2 Sommers Unknown 19s. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2722 Moorgate Road Baltimore, Maryland 21222 George Carrick / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 5/15/00 Towson, Maryland Hilltop Service Corp. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility The Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate the mode of dying, such as cardiac or respiratory arrest,

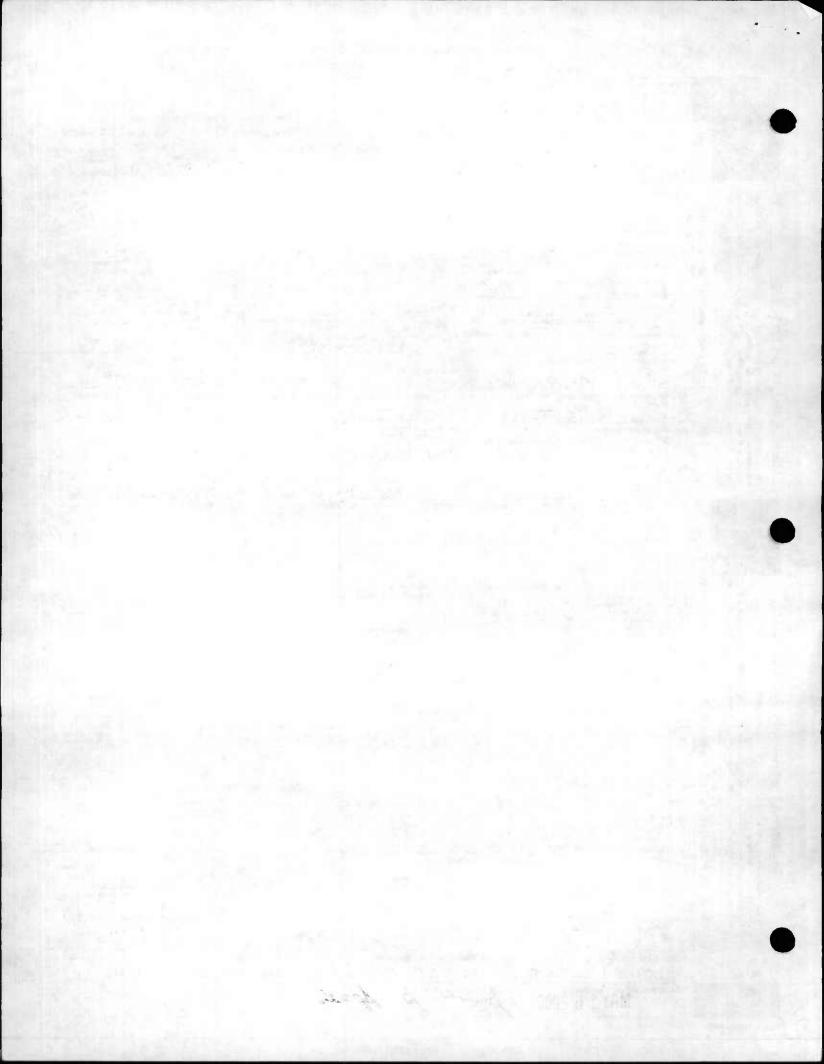
Approximate the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Arnythmia hour disease or condition resulting In death) Examiner Due to (or as a consequence of) Examine Cardionyopathi iclan and buriei-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physiclan Box 68760, Heart Discase 10 years Ischemic Physician/Medical Due to (or as a consequence of): the 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown Heart Failure Records, þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To this funeral To the Hospital or Attending PI within 24 hours after deeth.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred After 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcida Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Chitz 943494 May 12, 2000 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) Johnsttepkins Beyview Medical Center, Baltimore, MD 21224 Colleen Chinstones, MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAY 1 6 2000 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Daath Month Year Physician LARA MAY 9, 2000 SALATOA 1:06 PM /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 250 F Director Usuel Rasidence of Decedent 1908 NEWJERSZY pernit. Peges 1 end 2 should be flied within 72 hours efter death with the Maryfan Department of Health and Mental Hyglane.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with highly or other traumatic event, the Medical Examinar must be notified at pine. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Nas 2□No Director WASALAND BALlimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 910PT RVS U.S.A. AGLLW000 211234 Funeral Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 250 No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHIT 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry JOHNS HOPKINS Elemantary/Secondary (0-12) College (1-4or 5+) 10YRS-RETARY UnivERSi 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be KAINONS ADDA 1. SQUILANTI houis 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 31334 19a. Informant's Neme/Ralationship (Type, Print) BALTIMORE 1 PARYLAND 2706 INGLEWOOD AVE 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data MY 13 ₩ Burial 2 Cremation 3 Removal from State BALTIMORS 4 ☐ Donation 5 ☐ Other (Specify) 2000 IARYLAND Ozzoz 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility 4 6616 OFF EmpRills EVANS CHAPEL ROAD 8800 HARFORD PARTLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** tmmediata Causa (Final diseasa or condition rasulting in death) /Medical PNEUMONIA 3 DAYS Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physicien end for use as the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Records, P.O. Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2000 3 Probably 4 Unknown ate has been signed page 2 should be det à 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy is certificate t director, peg 22 No 1 Yas Division of Vitai or Attending Physician: 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Da Inpatient edicai Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of Death 1 Natural 28a, Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred After 5 Pending invastigation 1 Yas 2 No death. 2 Accident after deat Director: 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) completely filled in by 4 ☐ Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier ŝ 29b. Signatura and little of certified 29c. License number 29d. Date signed (Month, Day, Year) 2 D24034 C 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND TIMOTHY LOW, M.D. 21204 31. Data filed (Month, Day, Year) MAY 1 6 2000 32. Registrar's Signatura State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dayte Year **Physician** 16:30 Mary Hyde Craig 2000 MA /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Union Memorial Hospital If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 23, 1921 9. Birthplace (Stata or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country)
Pennsylvania 169-18-4752 Yrs. Director 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show lited within 72 hours after death with the Maryla Hygiens Hygens 23s or 28s-f show other than 'natural', or items 23s or 28s-f show ent, the Madical Examiner must be notified at Dundalk 1 Yes ZE No Director Maryland Baltimore 10e: Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 6700 Woodley Road United States Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 1 Yas 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yas ZONo Specify: à Specify: White 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Tin Mill 10 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental N permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itsm 27 is marked any Injury or other traumatic ex is marked Ameila Prate Michael Hyde 2 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6700 Woodley Road Baltimore, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Mr. Thomas Craig Jr. (Son) Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cametary, cramatory or other place) 20c. Location - City or Town, State ¥E3Burial 2 ☐ Cremation 3 ☐ Removal from Stata 5/12/2000 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part I. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final 2 DAYS SEPSIS disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): physician a Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE, ATHEROSCLEROTIC by Division of Vital Records. 24b. Wara autopsy tindings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed CARDIOVASCULAR DISEASE 1 Yas 2 No 1 Yes 25 No MELLITUS DIABETES Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation ours after death. eral Director: Al filled in by tha fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital of within 24 hours af To the Funeral D completally filled is 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and mannar stated. 29a. Certifier edical (Check only 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifiar MD AT2438946 9th 2000 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HOSPITAL, BALTIMORE, MD MATHEW JENNIFER UNION

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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216-26-7386	Sex 7. / 1 ☐ M 2 ☑ F	Age (In yrs. las 81	Yrs.	Months Da		Hours	Min.	8. Dete of Bi (Month, Di 2/14/1	Year)	Mars	place (Stete or For http:) 'Land
Isuel Residence of Decedent								2/14/1	717	rialy	Tanu
0a. State 10b. County	of Date			ation						T.	Od. Inside City Lin
MD Baltime	Balt	imore								1 □ Yes 🎘	
10e. Street and Number				10f. Zip Code					10g. Citizen of \	What Cou	ntry?
7436 Brookwood	Avenue										
	Armed Force	s?	S. 13. Wes Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri					ecify Yes or No Rican, etc.)	- 14. Rec Biad		
	If Yes, Give		1	□Yes 2√€	No 5	Specify:			Specify	. Whi	.te
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7. Father's Name (First, Middle, Las	t)				18	. Mother	's Name	(First, Middle	, Maiden Suman	10)	
John W. Wolfe		Ella Mae Gooding									
-	swell					Ave	. Ba				
rate and the second sec	☐Removal from Stat	сел	netery, crem	atory or other	place)		1	Dete	20c. Location -	City or To	own, State
4 □ Donation 5 □ Other (Spec	ity)	Gar						17/00	Baltimo	ore,	Maryland
1. Signature of Funeral Service Lio	insee 21	1					301				
No Control of the con										land	21206
shock, or heart fulfure. List only one cause on each line.										Approximete Interval Between	
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tmmediate Ceuse (Final disease or condition resulting in death)								2 Days			
Due to (or as a consequence of):											
Chronic Obstructive Pulmonary Disease/Severe/End Stage 16 Years											
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Alzneimer's Dem	enc1a							A			
Cerebrovascular	Accident	, old a	and Re	cent		24a. Was an autop parformed?				available prior to	
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3 ☐ Suicide 6 ☐ Could not	be on Diese of	niuny - At hom	a farm stre			. 201		28f Location	Street and Num!	oer or Pire	al Route Number
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9e. Certifier 1 ☑ Certifyi ng P	hysician: To the bes	st of my knowle	edge, deeth	occurred at th	e time	date end	plece	and due to the	ceuse(s) and me	enner as e	tated.
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9b. Signature and title of certifier	_			29c. Lic	ense nu	umber			29d. Date signe	d (Month,	Day, Year)
1 Chillian -	antas	M.	2	15	100/	1_7			May 12	2000	
0. Name end eddress of parson who	completed cause of	I death (item 2	3a) (Type, P		1034				riay 12/	2000	
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Please Type or Print in Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#5 PER F.H. #25 PER MD. G783 5-16-2000 JAB Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 74:15 John Capers 2000 04 04 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore, Maryland Bayview Medical Center Baltimore HOPKINS 5. Social Security Number 250-12-8403 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer Months Days Birthplace (Stete or Foreign Country) Funeral XXM 2 F Director 85 4/28/14 SC Usual Residence of Deceden with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle ? Is marked other than "natural", or flams 23a or 28a-f ahor traumatic avent, the Modical Examinar must be notified at No Yes 2□ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 400 MILLIMGTON AVE. APT. 109 21223 U.S.A. Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. orio 2 should be filed within 72 hours after to thealth end Mental Hygiene. 1 Never Married 2 Married Specify: BLACK 1□ Yes 2□ No Specify à 3D(Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 PILE DRIVER EMBACH CO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 end 2 should be Department of Health end Menta Important if Item 27 is merked. WILLIAM CAPERS ROSA LEE CAPERS 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDALLSTOWN MD. 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) ELIZABETH POWELL 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN CEM. 4/7/2000 BALTIMURE. MD. 22. Name end Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE, MARYLAND ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, i. List only one cause on each line. 23a. Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Physician /Modical Immediate Cause (Final Preumonia 2 weeks disease or condition resulting in death) Exa niner Due to (or as a consequence of): Examiner Subjuxation The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of) physician oppable Physician/Medical the Due to (or es e consequence of): 98 attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ should t 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy pege 2 : r this certificate h 200 1 Yas 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 1 Yes After this funeral o 28c. Injury at Work? 27. Mannar of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending deeth. 1 ☐ Yes 11:30PM investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) all birector: A 212 ccident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Records, Division of Vital or Attending Physician: To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Home 29a. Certifier 29b. Signature and title of certifier

400 Millington Ave

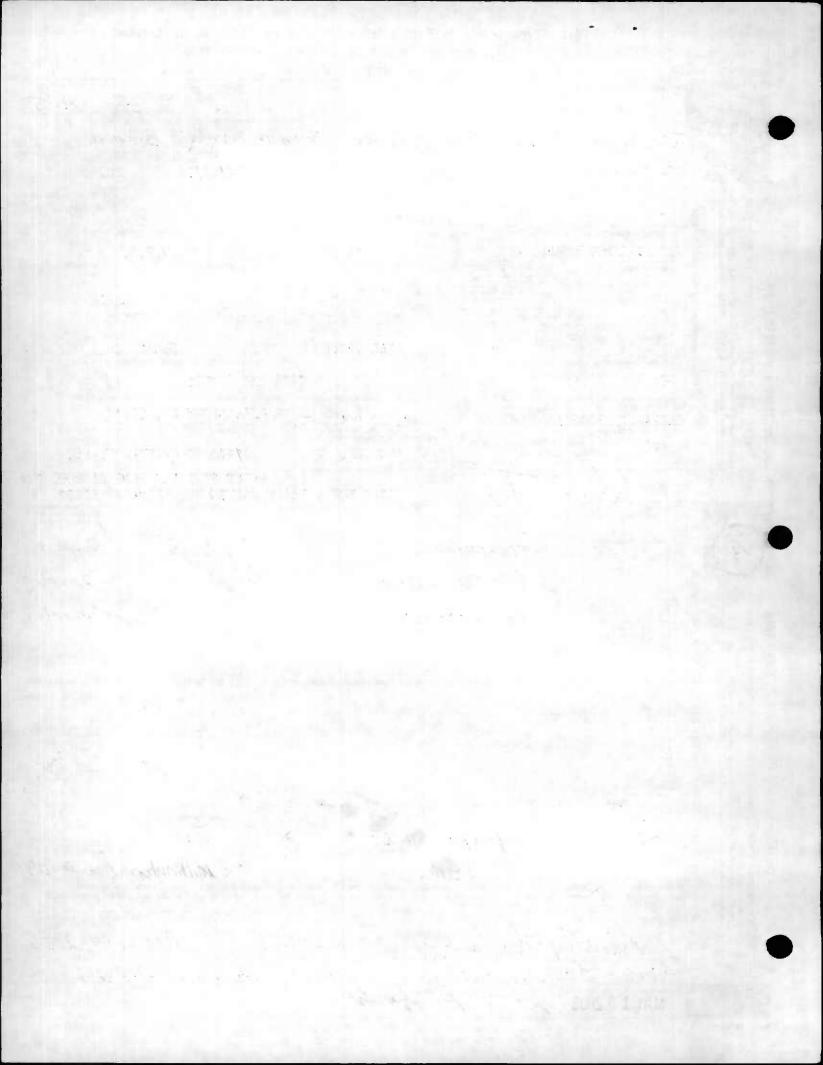
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

ted cause of death (tem 23a) (Type, Print)

Maryland 2/224 31. Date filed (Month, Day, Year) 32. Registrar's Senature MAY 1 6 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5595 Amended item #11 per FH g799 9/25/01 AH Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 2000 /Medical 4b_Gily 4c. County of Death 4a Facility Name (If not institution, give street and number) tion of D Examiner N/A B. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Y 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Hours Months 1 M 2 F 175-38-1502 53 MAR 13, Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?? Is marked other than "natural", or itema 23a or 28a-f show treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9 Eiffel Court 21221 USA Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Meritel Status 1 DYes 2 No
If Yes, Give
Year or Dates: Vietnam 1 Never Merried Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: Black € Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Haalth and Mental Hygien. Important: If fem 27 is marked other the any Injury or other treasment. Tractor Trailer Driver Trucking Company 17. Father'a Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Roy Hoard Alice Adele Craig 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Lorena Gibson/Daughter 666 Villager Circle Dundalk, MD 21222 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5-Other (Specify) Crematory, Inc. 5/10/00 Baltimore, MD 22. Name and Address of Facility
Cremation Society of MD, Inc. 21. Signature of Funeral Service License Edward Anerel Gregorchik Edward A. Frederick Road Baltimore, 21228 23a. Pert1. Enter the disease, or compile tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequenca of): Examine KASK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence et); the attending physician Box 68760 Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 2 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings evalleble prior to completion of cause of death? 24e. Wes en autopsy performed? Completed Hospital or Attending Physician: The lew 24 hours after death.
Funeral Director: After this certificate has stely filled in by the funeral director, page 2. 2 No 1 Yes 2 XNO 1 Yes LOMVORA Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar **DHMH 16 Rev 6/95**

29b. Signefure end title of sertific

31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture

npleted cause of death (Item 23e) (Type, Print)

mo

29c. License number

29d. Dete signed (Month, Dey, Year)

BAYLERW CIKER



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month MAY **Physician** 6, 2000 5:40 AM JAMES W. CHILDERS /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GAITHERSBURG MONTGOMERY WILSON NURSING HOME If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) June 21, 1906 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 1K) M 2 F Yrs 084-20-7238 93 TX Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow or herns 23s or 28s-f short in ner must be notified at Director VA 1√2 Yes 2 No Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5451 Summer Leaf Lane 22312 USA pemit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Meniel Hyglene. Important: If item 27 is marked other than "natural", or flema 23s emb injury or other traumatic event, the Medical Examiner mans base. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2KT Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 professor university 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) å James Washington Childers Martha E. Clark 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Childers/son 5451 Summer Leaf Lane Alexandria, VA 22312 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility
State Anatomy Board Director 655 W. Baltimore Street 21201 Baltimore, MD 23a Plut1. Entar tha disease, or com plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting In death) Dulmonar ed Examiner Due to (or as a con quence of): Examiner al rear physician and s the burial-transit The law requires that the desth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): US0 85 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown insonism page 2 should be del Records, à 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate 1 Yas 2 1 No 1 Yas 2 No Division of Vitai or Attending Physician: 8 25. Was casa refarred to medicat axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2. Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only 29b. Signature and life of certif 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama end addrass of person who completed cause of death (Illum (Type, Print) STEVEN DOLINSKY WILSON MURSING HOME; GAITHERS BURG, MU

DHMH 16 Rev 6/95

State Registrar

31. Deta filed (Month, Day, Year)

MAY 1

32. Registrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0 Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Day Year Month **Physician** 7:03 AM Mai 3 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** IMOVE amarisan If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Dey, 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplace (Steta or Foreign Country) **Funeral** Days 219-18-7255 Usual Rasidance of Decedant 1□ M 2**E**CF Yrs VIRGINIO **Director** the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits pemit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryler Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show any injury or other traumetic event, the Medical Examinat must be notified as 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21234 by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or Notif Yas, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Mantal Status 1 ☐ Never Merried 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: 人 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highest grade complated) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nonce 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fathar's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Baltimore entuseth Alt. 20c. Location - City or Town, State May 16 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica License vans 21234 880 OR 1. Entar tha disaase, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaan Onset end Death **Physician** Immediate Cause (Final disease or condition rasulting In daath) Probable Myocordia /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed ettending physician and for use es the bunel-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Olvision of Vital Records, P.O. Box 68760, that initiated evants resulting In death) Last Due to (or es e consequenca of): ate has been signed by the page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? certificate has been 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospitat or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was cesa referred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 22 ER/Outpatient 1 Inpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 🗆 No 2 Accident 6 Could not be datermined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 4 Homicida 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edical 29c. Licensa number 29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Day, Year) MAY 16

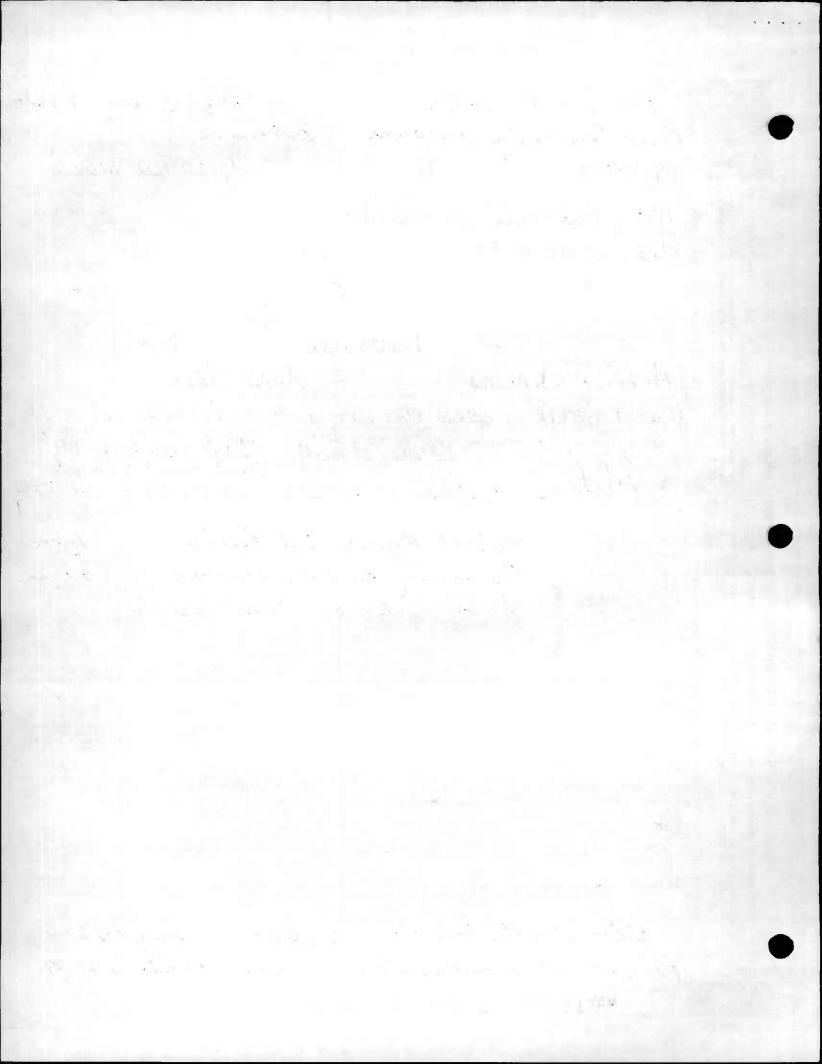
Edward Seidel MD,

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature end title of cartifier

32. Registrar's Signature

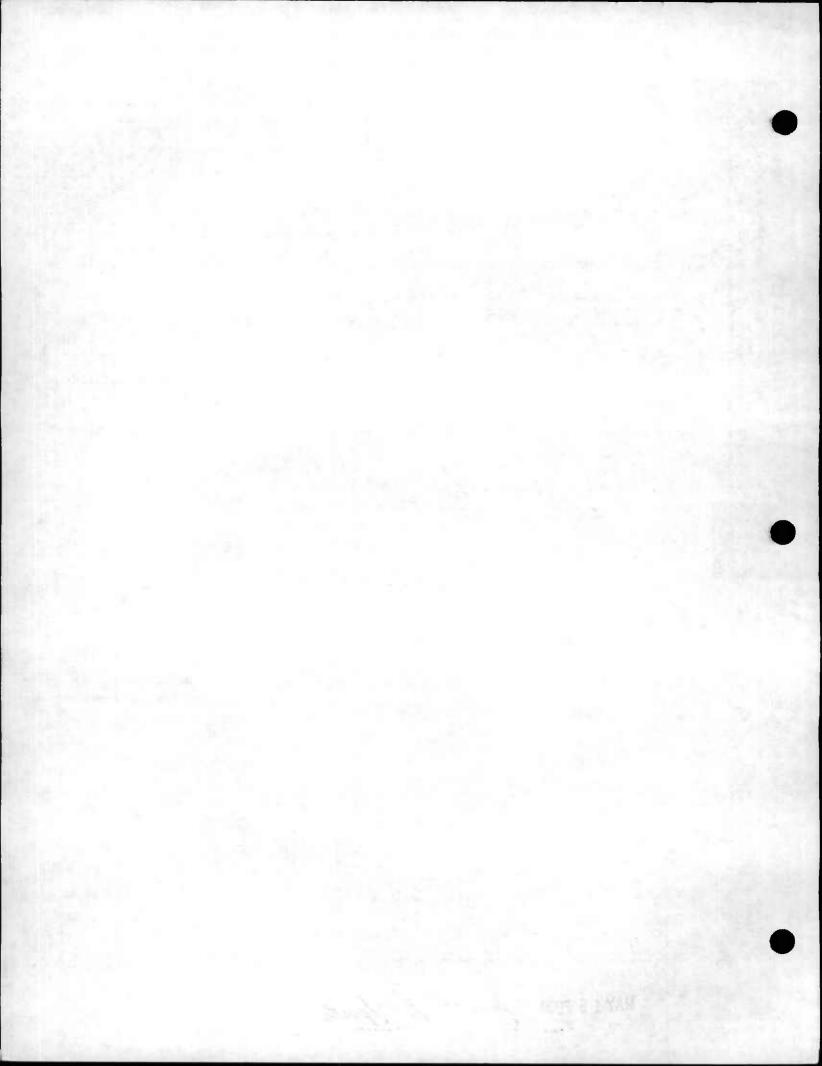
Baltimore, Maryland, 5601 Loch Kuven,



_	Decedent's Name (First, Middle, La	ist)	Cert	ificate of	Death	2. Date of De		3. Time of Death	
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Funeral Director	5. Social Security Number 6. s	If Under 24 Hrs Hours Min		th. Year) 1, 1927	Birthplace (State or Foreign Country) Italy				
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23a or 28a-f ahow unt be notified at al Director	Maryland Anne Ar		altimore					1 ☐ Yes 2X No	
128	10e. Street and Number		10f. Zip Code					Vhat Country?	
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by Funer	11. Maritel Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		as Decedent of I Yes, specify Cub	Hispanic Orlgin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Raci Blac Specify	a - American Indian, k, White, etc. White	
Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ducation ade completed) College (1-4or 5+)	(Give ki	nt's Usual Occup ind of work done O NOT use retire	pation during most of wo d)	rking	16b. Kind of Business/Industry Suit Company		
, D	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,			
To Be Co		milo Pettenuz	zo					available)	
E	19a. Informant's Name/Relationship	Type, Print)	19b. Meiting	Address (Stree	and Number or R	ural Route Numb	per, City or Town, State, Zip Code)		
or trau	Rino Dalla Muta	/ Husband	432 CI	hurch St	reet	Baltimo	ore, Mar	yland 21225	
Important: If item 27 is marke eny injury or other traumatic phice.	20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 X Other (Speci		cometen crems	tony or other pla	ce) rial Parl	5/15/00			
important: eny injury phos.	21. Signeture of Funeral Service Lice	ramiscuf							
ysician ledical aminer	23a. Part1. Enter the disease of conshock, or heart failure. List only immediate Ceuse (Final disease or condition resulting in death)	plicetions that caused the de one cause on each line.	Glen Haven Memorial Park 5/15/00 Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 The death. Do not enter the mode of dylng, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death						
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this ceral direction.	axaminer? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Ot	her:	Home 5 ☐ Resi		er (Specify)	
Minimary four state death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investigation		28b. Time of Injury	M 1	ryat rk?]Yes 2 □ No	28d. Describe	how injury occurr	red	
led in by	3 Suicide 6 Could not be determined	building, etc. (Spec	cify)			City or To	wn, Stete)	er or Rural Route Number,	
To the Funeral completely filled Medical C	29a. Certifier 1 ☐ Certifying Pt (Check only one) 2 ☐ Medical Exam	ysician: To the best of my ki niner: On the basis of exami and manner stated.	nowledge, death on nation and/or inve	occurred at the ti stigation, In my	me, date and plac opinion, deeth occ	e, and due to the urred et the time,	cause(s) and ma date end place,	nner as stated. end due to the ceuse(s)	
Tot	29b. Signature and title of certifier M. Forces	, MO , PC	4-1 INTE	29c. Licen			-	d (Month, Day, Year)	
5	30. Neme end eddress of person who MARINA FAR.	completed cause of deeth (It	em 23a) (Type, Pi SOUTH F	rint) HANOUER	STREET	, DAL	TIMORE	MD 2/225	
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sig		1					

DHMH 16 Rev 6/95

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or 28g	lrec	10a. Straat and Number			10f. Zip Coda		10g. Citizan of What Country?			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month 15, Mary Teresa DeMinter 2000 May 4:10AM 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath Stella Maris Hospice Timonium Baltimore 8. Data of Birth (Month, Day, Yaar) OCT 21, 1938 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Days Hours 10 M X0 F Months 61 031-28-4555 Massachusetts Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Virginia N/A Alexandria 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1225 Martha Custis Dr., Apt. 706 22302 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas ☒☐ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black White, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant'a Education (Specify only highast grada complated) 16b. Kind of Businass/Industry National Academy Collega (1-4or 5+) Elementary/Secondary (0-12) Project Assistant of Science 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) H. D. McConnell Edna Wood 19a. Informant's Name/Ralationship (Type, Pnnt) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 416 Leitch Rd., Tracys Landing, MD 20779 Elizabeth McConnell/Sister 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Slata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from State Metro Crematory, Inc. 5/15/00 Baltimore, 4 Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Libensee Edward A. Greg 22. Name and Address of Facility Cremation Society of Maryland, Inc. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Metastatic Cancel' Immediata Causa (Final disaasa or condition resulting in death) Sequentially list conditions, if any, leading to immadiala causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Lasi Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy 24b. Wara autopsy findings available prior to complation of causa of death? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding investigation 1 Yas 2 No

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Physician/Medical by Completed Be To Certification:

edical

2 Accidant

4 ☐ Homicide

(Check only

29b. Signatura and title of certifian

3 Suicida

29a. Certifiar

6 Could not be determined

Physician

/Medical

Examiner

Directo

Funeral

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Be

2

Examiner

Funeral

Director

r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at

hours after

Hygiene.

permit. Pages 1 and 2 should be till.
Department of Health and Mental Hy
Important: If Item 27 is merked oth
any injury or other traumetic event

Physician /Medical

Examiner

altimore, Maryland 21215-0020

I Director: After ti To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After filled in by

To the Fune

Registrar

DHMH 16 Rev 6/95

30. Name end addrass of person who complated causa of death (Itam 23a) (Type, Print) Back River Neck Road Baltimore TARIQ MALTMOUD 201 31. Data filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29c. Licanse number

D43725

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

MD21221

5/15/00

32. Registrar's Signatura MAY 1 5 2000

28a. Place of Injury - Al homa, farm, streal, factory, office building, atc. (Specify)

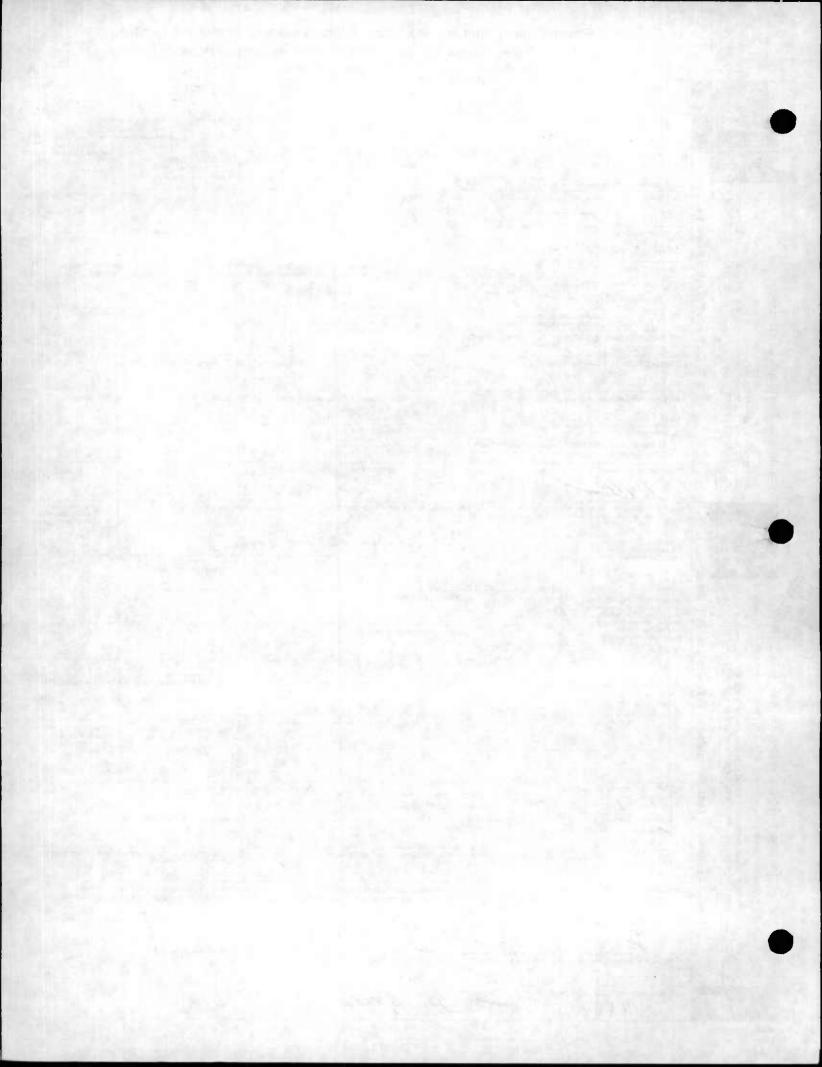
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ledical aminer	4a Fecility Neme (If not institution, give strate and	nd number)		4b. City, Town, or		4c. County of				
	VA MARYLAND HEALTH CA			PERRY I		CECIL				
eral etor	5. Social Security Number 218-18-1081 Usuai Residence of Decedent	7. Age (In yrs. last	birthday) If Under 1 Yes Yrs. Months Dey		8. Dete of Birth (Month, Day,	1914 1	Birthpiece (State or Forei Country)			
tor	10a. State 10b. County Md. Baltmak	10c. City, To	PKVILLO	W, 1			10d. Inside City Limi 1 ☐ Yes 2 📜			
al Director	10e. Street and Number	1	1311	10	g. Citizen of Whe	t Country?				
Funeral	11. Meritel Stetus 12. Was	Decedent Ever in U.S.	13. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-		American Indien,			
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0000	20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel !	come	of Disposition (Name of tery, crematory or other p	lace)	May 16 2	Oc. Location - Cit	y or Town, Stete			
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DOC	21. Signature of Funeral Service Infenses	Wells	22. Name end Add	ress of Fecility	vans Fu	reeal C	napele			
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest. Approximate Intervel Between the disease on each line.									
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician AGATHA** MARY ENA 3:30 a.m. Mav 13, 2000 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4540 Parkside Drive Baltimore If Under 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2 DEF 212-20-7102 Director 93 May 10, 1907 Italy Usual Residence of Decedent deeth with the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limita show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Ves 2 No Director Baltimore 10f. Zip Coda 10g. Citizan of What Country? 10e Street and Number 4540 Parkside Drive 21206 U.S.A. Funeral Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yas, apecify Cuban, Maxicen, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or frei any highry or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 X No If Yas, Giva 1 Navar Married 2 Married Saitimore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify: þ 3 Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grads completed) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Own Home 8 th grade Homemaker 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Paul Santoni Allessandra Capone 19a. Informant'a Name/Reletionship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Joseph Ena- Son 4540 Parkside Dr., Baltimore, MD 21206 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burla1 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) Most Holy Redeemer 5/16/00 Baltimore, MD 22. Name end Address of Fecility Leonard J. Ruck Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensea William G. Dau 5305 Harford Rd., Balt., MD 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onsat and Daath Physician Immediata Causa (Final disease or condition resulting in death) */Medical Examine Dua to (or as a consequanca of): Examine that the daeth certificate be axecuted physician end is the burial-trens Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in deeth) Lest Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequenca of): NS6 P.O. Part It. Other significant conditions contributing to death but not resulting in the undertying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an eutopsy performad? Completed page 2 has 20 No 1 Yas 1 Yas 2 No Division of Vital Be 25. Was cesa referred to medical 26. Placa of Death (Check only ona) Hospitel: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2 No 2 this 28a. Deta of Injury (Month, Day Year) edical Certification: 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? After t Hospital or Attending 24 hours after death. 5 Panding invastigation Netural 1 Yas 2 No 2 Accident Director: / 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At homa, farm, atreat, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to the causa(a) and mannar stated. 29a Certifier 29d. Data signad (Month, Day, Year) 29c. License number 29b. Signature and titla of certifiar 00 30. Nama end eddrass of person who complated ceusa of death (Itam 23a) (Type, Print) M.D. 201 E. Gregory L. Walker, University Pkwy, Balt., MD 21218 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State MAY 1 6 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death 1.48 **Physician** 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath Examiner HOSP. BALTIMORE OF MARYLANES If Undar 1 Year Months Days If Under 24 Hrs. Hours | Min. 8. Data of Birth (Month, Dey 7. Aga (In yrs. last birthdey) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 2 F Director with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 23a or 28a-f ahow 1 Yes 2 No Funeral Director 10e. Street and Number 10f Zip Code 10g. Citizan of What Country? 30 21234 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mental Hygiens. Important: If Item 27 is marked other than "natural", or Hearn any Injury or other traumatic access 16 Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 11. Maritaf Status 1 ☐ Yas 2 X No If Yas, Giva 1 Navar Married 2 Married Specify: Which Maryland 21215-0020 1 Yas 2 No Specify. þ 3 Widowed 4 □ Divorced Year or Datas: Be Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Gode) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Mathod of Disposition City or Town, State May 17 1 Surial 2 □ Cremation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility 23a- Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sech as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician /Medical Immediate Cause (Finat diseasa or condition resulting in death) Examiner Examiner use as the bunal-transit The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in daath) Last Box 68760, signed by the attending physician d be detached for use as the buria Completed by Physician/Medical 23b. Did tobacco use contribute to the causa of death? Part II. Other eignificant conditions contributing to death but not rasulting in the undarlying cause givan in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? 2 No 1 Yas ZUNO 1 ☐ Yas tal or Attanding Physician: The start death. al Director: After this certificated in by the funeral director, p. 25. Was casa referred to medical axaminar? Certification: To Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yas 2 No Nonpatiant 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Yas 2 No 2 Accidant 8 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Ptaca of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

DHMH 16 Rev 6/95

State

Registrar

29b. Signature and title of certifian

31. Data filed (Month Dev

30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Year)

16

4501

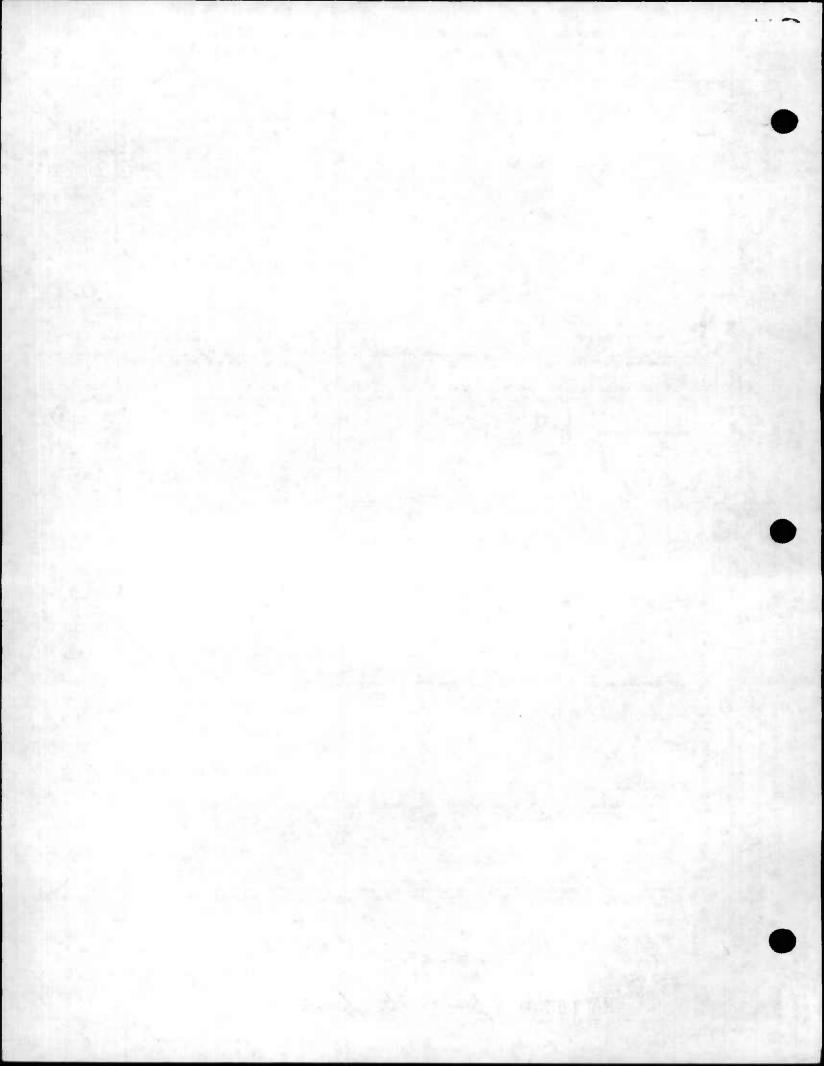
SAMARITAN

32. Registrar's Signatura

29c. Licansa number

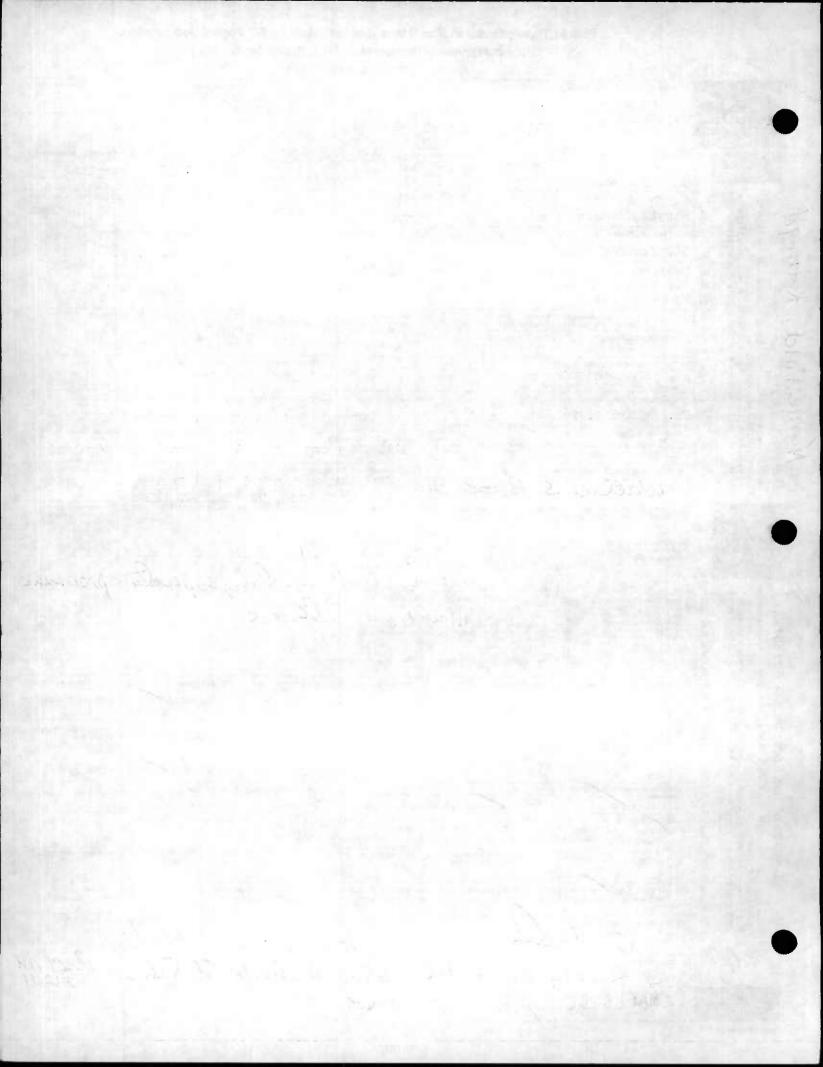
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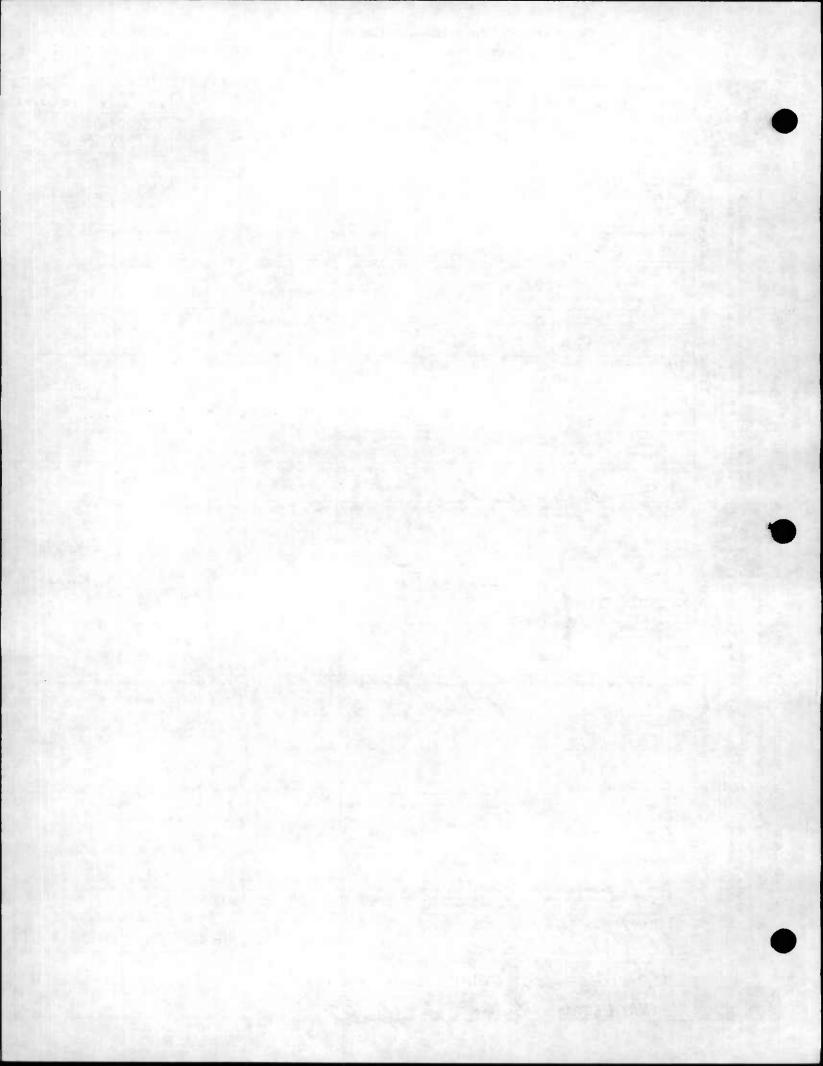
State of Maryland / Department of Health and Mental Hygiene 0 1560

and the				Certifica	ate of L	Death			Reg. No.			
hysician /Medical	1. Decedent's Name (First, Middle, Last) Kathryn Ruth Fuld							Month MAY 14 Dey 2000 Year		3. Time of Deal 2:48 p1		
Examiner	GREATER BALTIMORE MEDICAL CENTER						wn, or Lo	ocation of Dee	th 4c. County BALT	4c. County of Deeth BALTIMORE		
uneral rector	215-82-0282	Sex 7. A 1 □ M 2 □ F	Advertised De				24 Hrs. Min.	8. Date of Bi (Month, D 10-19	f Birth , Day, Year) 19-1915 9. Birthplece (State of Country) Maryland			
and or terms 23e or 28e-f show Evanisher must be notified at by Funeral Director	10a. Stete 10b. County									1	0d. Inside City Li	
	Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code								10g. Citizen of N	What Cour	ntov?	
	640 Yarmouth Road 21286										,	
	11. Meritel Status	13. Was Dec			ain? (Sp	ecify Yes or N	U . S		an Indien.			
	3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 X If Yes, Give Yeer or Dates:		ver in U,S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puert 1 □ Yes 2 No Specify:						ck, White, y: Whi		
t, the Medical Completed	15. Decedent's E (Specify only highest gr. Elementery/Secondery (0-12) 1.2	ducation ade completed) College (1-4or		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Homemaker				ing	16b. Kind of B	usiness/in		
ic event, the	17. Fether's Neme (First, Middle, Last Sherman Wis		TOMONO	IXCI			e (First, Middle Morris	a, <i>Maid</i> en Suman		е		
T met	19a. Informant's Neme/Relationship	(Tuna Brint)	10h	Mailing Addre	on /Ctront	and Alumbi	or or Pur	al Porto Numi	oer, City or Town,	Ctato 7in	Code	
11	Mr. Hubert H. Ful			640 Ya								
ther to	20e. Method of Disposition	u (Husban	20h Place of	Disposition (A	lame of		au,	Date	, Maryla			
lury or o	1 Ø Buriel 2 □ Cremetion 3 □ Removel from Stete cemetery, crematory or other place) 4 □ Donetion 5 □ Other (Specify) 5-							5-18-00 Brooklyn, Maryland				
any ir	21. Signeture of Funeral Service Licensee Wallace S Brook, 21 - 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204											
ending physician and use as the burial-transit aurimetransit Ceuse (Diseese or injury thet initiated events resulting in death) Lest	b	Due to (or as a complete to (o	consequence of the consequence o	and so	de	de	en, o	puol	ten ,	Droum		
by the etter tached for the hysicial	Pert II. Other significant conditions	iditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause o				
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hes been sign. ge 2 should be mpleted by								part	s en autopsy ormed?	ev cc of	ere autopsy findi alleble prior to impletion of caus death?	
rector, page Co		1 Yes 2 No 1 Yes 2 No No No No No No N									J Tes ZLINO	
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		28e. Dete of inj (Month, Di	28e. Dete of Injury (Month, Day Year) 28b. Time of Injury at Work?					Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
al Director: After to led in by the funera Certification:	3 Suicide 6 Could not be determined	286. Pleca of in	28e. Pleca of Injury - At home, term, street, tectory, office building, etc. (Specify)					281. Location (Street and Number or Rural Route Number City or Town, State)				
Funer tely fil	29a. Certifier 1 Certifying Pr (Check only one) 1 Medical Example	nysician: To the best miner: On the basis of and manners	of examinetion and	, death occurred/or investigati	ed at the tim on, in my o	ne, date an pinion, dea	d place, th occur	and due to the red at the time	cause(s) and m , date and place,	anner es s and due t	tated. the ceuse(s)	
completely filled Medical Ce	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cone) 29b. Signature end title of certifier 29c. License number 29d. Date signed Month, Day,									Day, Year)		
Z E S	+ 18792 5/15/0								(Oc)			
To Some	30. Neme end address of person who	completed cause of	death (Item 23e) (Type, Print)	H 1	N.()	ani	165	f SuD	615	- BOOD	



State of Maryland / Department of Health and Mental Hygiene 0 15605

	Certificate of Death Reg. No.											
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Physician /Medical	John T					5	13	200	0 12:12 PM			
Examiner	4a Facility Nama (If not institution University of	1	45.00	Bc. 1-		ocation of Deeth 4c. Count		of Death	re			
Funeral Director	5. Social Security Number 216–10–3682	6. Sex 1√2 M 2□ F	7. Aga (In yrs. last 89	birthday) Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Dete of Bir 1 1/10/	1910	9. Birthplace (State or Foraig Country) Maryland		
2	Usual Residence of Decedant 10a. Stata 10b. Count		10c. City, To		antina						and trailed after the bar	
e Maryla la-f ahon tradat ctor		/A		timo						'	0d. Insida City Limits 1,	
72 hours enter deeth with the Maryland natural; or thems 23a or 25a-f show dical Examiner must be notified at eted by Funeral Director	10e. Street and Number 10f. Zip Coda								10g. Citizen of V	Vhet Coun	try?	
									U.S.	Α.		
	11. Marital Status 1 □ Never Merriad 🏖 📆 Ma	dant Evar in U,S. cas? 2 No	If Yas, specify Cuban, Mexicen, Puarto Rican, atc.)						e - Amaric k, Whita,	atc.		
b Fig.	3 ☐ Widowed 4 ☐ Divorce	d If Yas, Giv Yaar or Da	a itas:	,	I□Yas 2½DN	o Specify:			Specify	Whi	te	
	15. Deceda (Specify only high	nt's Education ast grada completad)		6a. Deced (Give I	lent's Usual Occ kind of work don OO NOT usa reti	upation a during mos	at of work	ing	16b. Kind of Bu	isinass/Inc	dustry	
Hygiene. ther than ent, me as Comp	Elementary/Secondary (0-12)	y (0-12) Collega (1-4or 5+)			ger				Lucas			
T T T T	17. Father's Name (First, Middle	. Last)		Talla	ger	18. Moth	ar's Nam	a (First, Middla	, Maidan Sumem	e)		
marked othe imatic avent, To Be C	John J. Frank		Marie B. Hen									
7 la m traum	19a. Informant's Name/Ralation Alvina Callaha									City or Town, Stata, Zip Code) ALabama 35055		
if item 27 or other tr	20a. Method of Disposition	20a. Method of Disposition 20b. Pl					1	Data				
# >	1 ☑Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (f Faith		erv5	/17/00	Baltimore, Maryland				
원급.									ohn C. Miller Inc.			
any i	6415 Belair Road Baltimore, Maryl										21206	
/sician ledical aminer	23a. Par Enter San Canada San Can		ach lina. Troke	o not anta	ar the moda of d	ying, such as	cardiac	or respiretory a	rrast,		Approximata Interval Batween Onset and Death	
	rasulting in death)	a.	Dua to (or as	a consaq	uance of):						2 days	
ii.	Atrial Fibrillation									1 Known		
ise as the bunal-transit	Sequentialty list conditions, if any, leeding to immediate cause. Enter Undertrying Cause (Disease or injury thet initieted evants rasulting in death) Last Dua to (or as a consequence of):											
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ctor: After thi y tha funeral flcation: T	27. Mannar of Death 1 Natural 5 Pend 2 Accident invest	28a. Data o	1	b. Tima of Injury	28c. In			ma 5 ☐ Rasidance 6 ☐ Othar (Specify) 28d. Dascribe how injury occurred				
To the Funeral Diractor: After this completaly filled in by the funeral di Medical Certification: To	3 Suicide 6 Could 4 Homicida detan	a, farm, streat, factory, office 28f. L					f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)					
completely filled		ng Physician: To that Examiner: On the ba	sis of axaminetion									
To the Fu	29b. Signature and title of certific		ar siates.		29c. Lica	nse number			29d. Date signe	d (Month.	Day, Year)	
8	1 Ath	MW) Nex	iolosy eside		469			5/13.	1		
1()	30. Name and address of person		of daath (Item 23			11	1		- C 199			
	or phu /Va/	mo m) U	mms:	130/	rimore	-, VVI	1)					
State Registrar	31. Data filed (Month, Day, Year		gistrar's Signatura		1:							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #17,18 PER FH G783 5/23/2000 AH Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Mitsa Freeland May 2000 10:50 A.M. 11 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARUNDEL ober 6. Sex NORTH A
5. Social Security Number GIEN BURNIE ar If Undar 24 Hrs. 8. Data of HOSPITAL ANNE ARUNDEZ If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F 213 30 5288 74 Director May 15, Egypt Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limita 1 Yas 2K No Maryland Anne Arundel Baltimore Directo 288-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4500 Belle Grove Road 21225 U.S. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married 1 Yas 2 No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Secretary / Bookkeeper Federal Tin & Paper Cd. 12th 2 years 18. Mothar'a Nama (First, Middla, Maidan Sumama) DESPINA K CALGY 17. Fathar's Name (First, Middla, Last) Be SPRATIS KVALGY is marked of Pages 1 and 2 should be (not available) (not available 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Department of Health Important: If Item 27 i Elmer Freeland / Husband 4500 Belle Grove Road Baltimore, Maryland 21225 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 5/16/00 Towson, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 21. Signature of Funeral Service Licensea 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 mamerousa 234. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. Unit only one cause on each line. Approximata Intervel Between Onset and Daath **Physician** Immediate Ceuse (Finel diseasa or condition rasulting In death) /Medical Examiner Examiner don be executed Sequentially list conditions, if any, leeding to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or es a consequence of): Be Completed by Physiclan/Medical The lew requires that the deeth certificate Dua to (or as a consequance of): P.O. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceusa givan in Part I. 23b. Did tobacco use pontribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was en autopsy performed? 24b. Ware autopsy findings availabla prior to complation of ceusa of death? 2/2 No 1 Yas 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona)

of Vital Records, or Attending Physician: funeral After Division s after death.

I Director: After the further than the fu filled in by

edicai Certification: To

25. Wes casa referred to medice! examinar? 1 Yes 2 No 27. Menner of Death 1 Natural

29b. Signature and titla of certifiar

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier (Check only one) 5 Pending invastigation

6 Could not be determined

1 Impatiant 28a. Data of Injury (Month, Day Year)

Hospital:

2 ER/Outpatient 3 DOA

28c. Injury et Work? 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

1 Yas 2 No

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

21208

29c. Licensa number 121225

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as ateled.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

Baltimore Mis

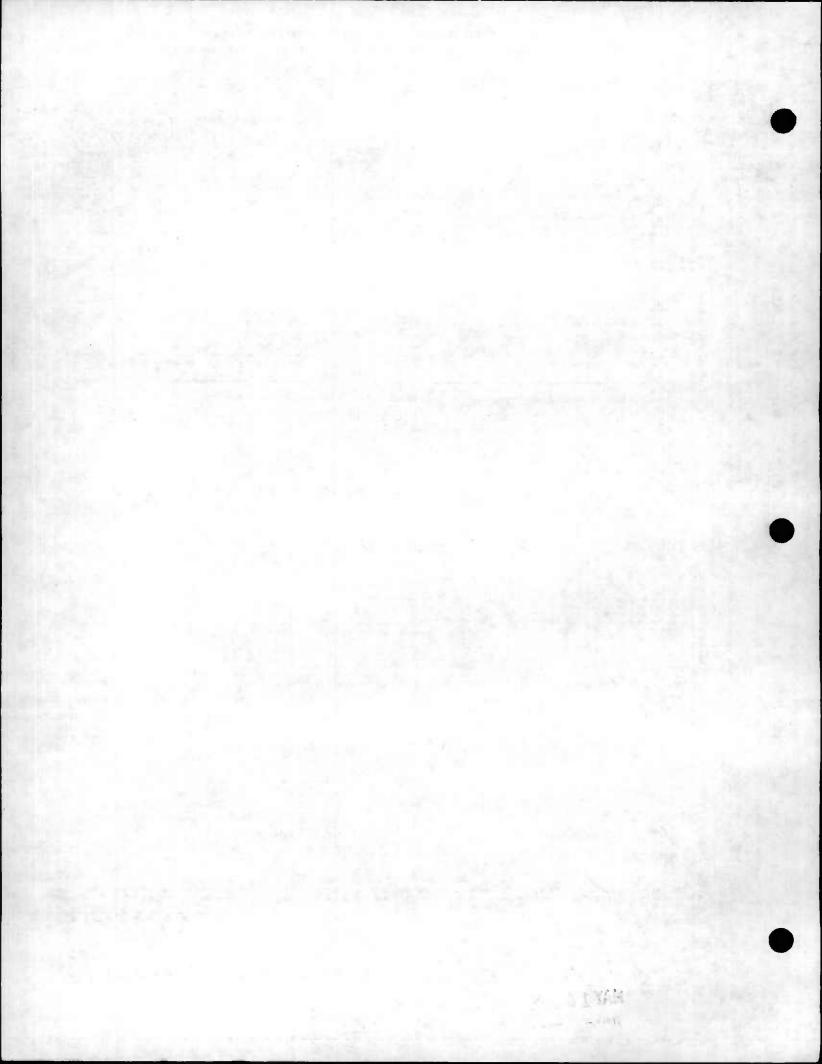
30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) Lemel 1838612Pue Tree Co

32. Registrar's Signatura

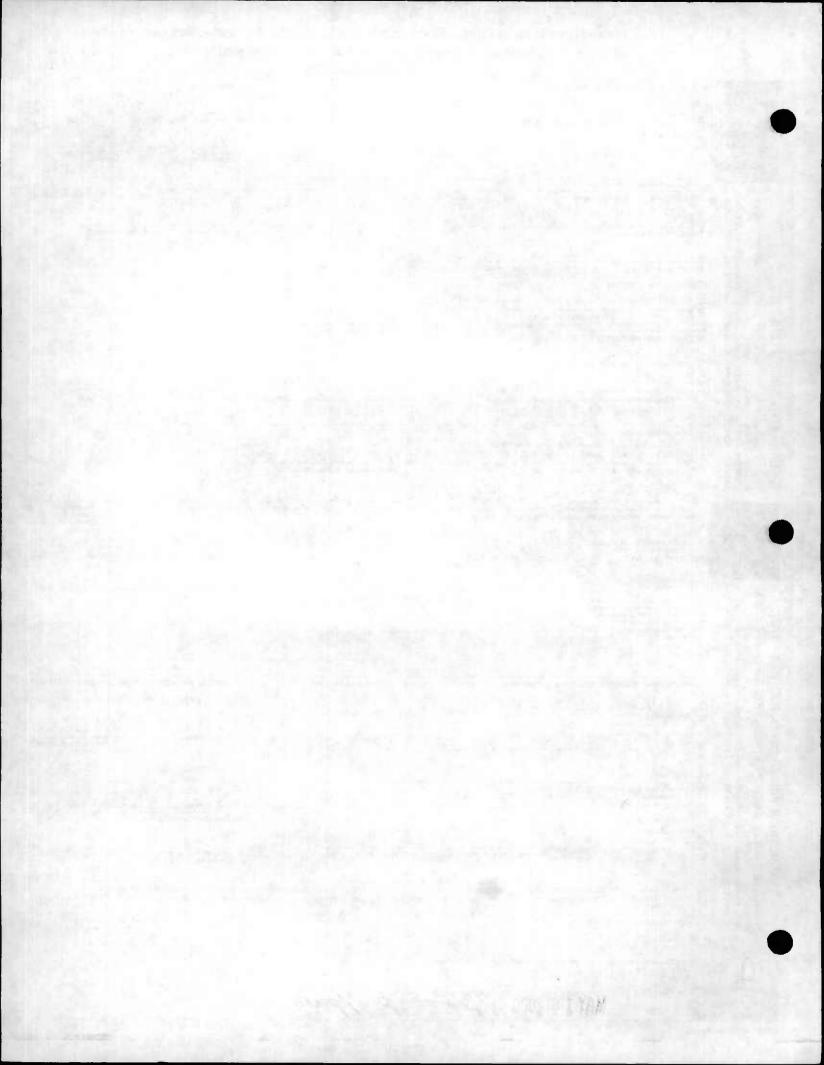
Registrar **DHMH 16 Rev 6/95**

State

To the Hospital o within 24 hours af To the Funeral Di completely filled in



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** JAMES A. FROBERG 2000 2:00 AM 3 May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Baltimore 20 Delight Avenue If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 28,1933 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 € M 2 □ F 67 Yrs Director 197-26-8932 Ridgway, PA. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'netural', or items 23s or 28s-f show diesi Exempler must be notified at Baltimore County-Fullerton Maryland Baltimore 1 Yas 2 No Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 21236 20 Delight Avenue USA death Funeral permit. Pages 1 and 2 should be filled within 72 hours after deal Department of Health end Mentel Hygiene. Important: If frem 27 is marked other than any flury or other traumate. 12. Was Decedent Ever in U,S. Anned Forces? 1 DYes 2 □ NKOTE an Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2)X) Married 1 ☐ Yas 2 No Specify: Specify: White þ ff Yes, Give Year or Date Conflict 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DAP, Inc. Inventory Planner 12 yrs. 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Clifford Frobera Florence Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mrs. Agnes E. Froberg 20 Delight Avenue Baltimore, Md. 21236 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Ramovat from State Garrison Forest VA Cem. 5-8-00 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Lassahn Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Maryland, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) ATHEROSCUEROTIC CORONARY ARTERY Examiner Examiner physicien and the buriel-transit that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TEROL Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 2 No 1 Yas 2 No Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5. Residence 6 Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred After or Attending 1 Natural 5 Pending Invastigation 1 Yes 2 No after death. I Director: A 2 Accident 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 6 Coutd not be datarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital owithin 24 hours aff To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 200° 34249 Harlan M 30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER J. ZAJAC MD 8817 BELAIR ROAD - BALTIMORE, MD 21236 31. Date filed (Month, 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1:00pm enneth may 2000 /Medical 4d. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner akcrest CARE Cente BARTIME WI If Under 24 Hts. Hours Min. 8. Date of Birth (Month, Dey., 6. Sex 1 M 2 F If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 14-5784 Months Yrs. MO Director Usual Residence of Decedant 3 2000 1:00 P. M Maryland 21215-0020 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or Nema 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at BALTI MOLL 1 ☐ Yas 2 No Director 10f. Zip Code 10g. Citizen of What Country? 1.5.A. Wouds Ver. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 No Specify: Specify: permit. Pages 1 and 2 should be filed within 72 hours. Department of Health end Mental Hygiene. Important if Nem 27 Is marked other than "natural", of Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) BALTI MORE CITY Elementary/Secondary (0-12) College (1-4or 5+) CAPTAIN 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be 2 Fritsch GrAZE NINKOP 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) swerence Ferdt Important; if item 27 is any injury or other tra once. Perry Woods Pery Will, Md. 21234 Nepran 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETON 16,200 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License CONNELLY FUNER Home of DUNDAUC, P.A. 23a. Part1. Enter the disease, or complications that caused the dear to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Dementit ouri c Syecur! Examiner mellits 20 years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Prostate CA 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of daath? Peripheral Arten Disease Completed 24a. Was an autopsy 1 Yes 25 NO 1 Yes 2 No 25. Was casa rafarred to medical examiner? 1 ☐ Yes 2 No Be 26. Placa of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ö 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Division Anending Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident Director 6 ☐ Could not be detarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) e Funeral Direct details filled in by 4 Homicida à edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian To the Fune completely f (Check only one) To the To the F 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number Nunel 17 D30182 30. Name and addrass of parson who completed causa of death (Item 23a) (Type, Print) WILLIAM RUSSELL BROD WPalther DIUL Parkville MD 21234 31. Date filed (MANIAMAY, 1648 2000) 32. Registrar's Signature

State Registrar

31. Date filed (MMAA), Loaf 2000

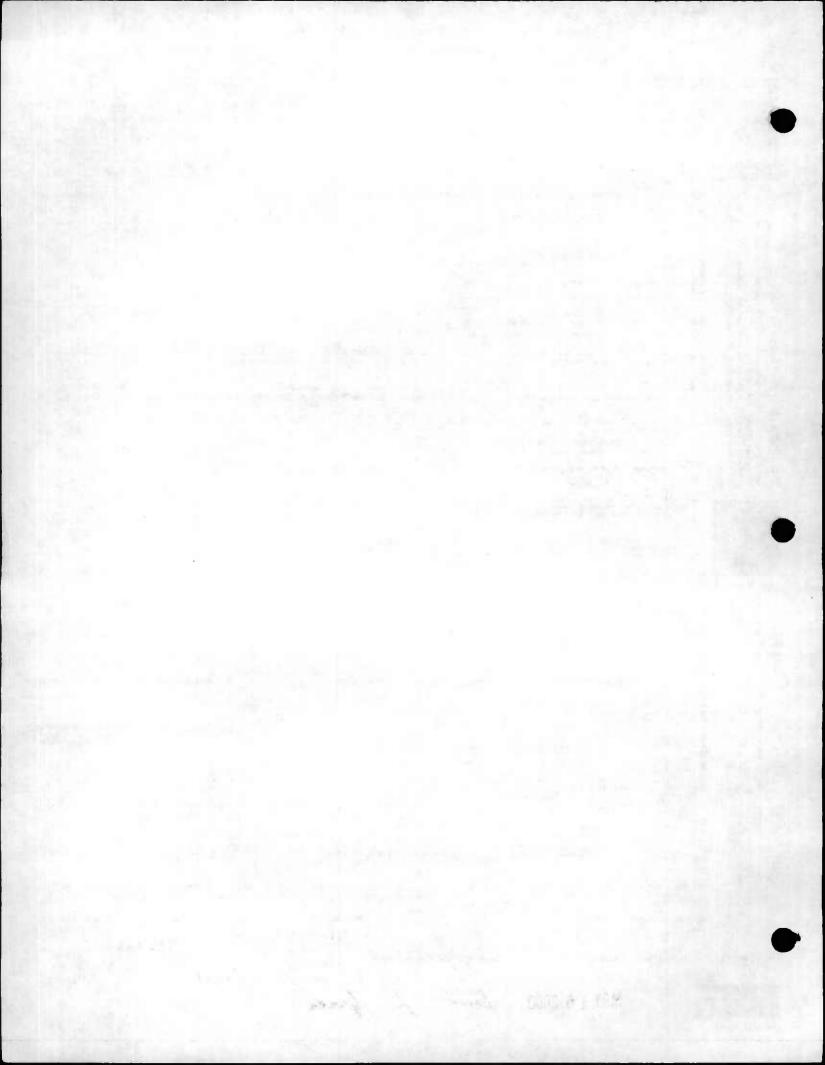
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VIRGINIA

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Yee GARL, P 4c. County of Death <00012 lau /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) **Examiner** Baltimore Franklin Square Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Kosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Philippens) **Funeral** Months 9438 **№** M 2□ F Yrs. AUG. 16, 1924 Director 160 62 Usuel Residence of Decedant with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23s or 28s-f show avant, the Medical Examiner must be notified at 1 Yes 28 No Director MARYLAND BALTIMORS HAU 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5R 21236 Funerai FOX LANS 12. Wes Decadent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Raca - Americen Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Yes 28 No If Yas, Giva Year or Detes: 1 ☐ Never Merried 25€ Merried ò 1 Yas 28 No Specify. Be Completed by PHILIPPINO 3 Widowed 4 Divorced "netural" 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry 2121 Peges 1 and 2 should be filed within nent of Heelth end Mental Hygiene. ent: if Itam 27 Ie marked other than " Elementary/Secondery (0-12) College (1-4or 5+) 2 PHOSNIX. 10 YRS 4 YRS MAILUZAGO 5 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnema) 0 GONZALES (AZARETH GARLIA OZTAS LANGEL RISPINA other traumatic 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21236 19e. Informant's Neme/Reletionship (Type, Pnint) reig, GARLIF ALL MARYLAND 20c. Location - City or Town, Steta 8 FOX BRIER HERRY HALL mportant: If Itam 27 I LUMINADA 20b. Place of Disposition (Name of cematary, crametory or other place) 20a. Method of Disposition JAY 23 8 Buriel 2 Cremetion 3 Removel from Stata HIMLAYAN NO TANAUAN 2000 Department BATANGES THILIPPINE 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Eacility OF PLORIZE 21. Signature of Fuggral Service Licensee 21234 8800 HARFORD (COAO) PARYLAND that caused the deeth. Do not antar the mode of dying, such as cardiec or respiretory errest, course on each line. 23a. Part1. Enter the diseese, or complication shock, or heert feilure. List only one cause Approximata Intervel Batween Onset end Death **Physician** Immediate Cause (Finel disease or condition rasulting in death) /Medical · Arrhythmia Examiner Due to (or es a consequance of): Physician/Medical Examiner Ar 15-695 oronar Attending Physician: The law requires that the death certificate be executed use es the buriel-tran Sequentially list conditions, if any, laeding to immediate causa. Enter Underlying Causa (Disaasa or injury that initiated events Due to (or as a consequenca of): Rena Box 68760, hronic Due to (or es e consequence of) resulting in death) Last tension Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Cerebrorascular Accident 1 Yes 2 No 1 Yes 2 No certificate 25. Wes case raferred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this al or Atternate destr. Ara after deeth. Aral Director: After the high the funer. 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturet 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 Suicida Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and mennar es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 9026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Michael Dwyer 9000 Frank Michael tranklin Lar

State

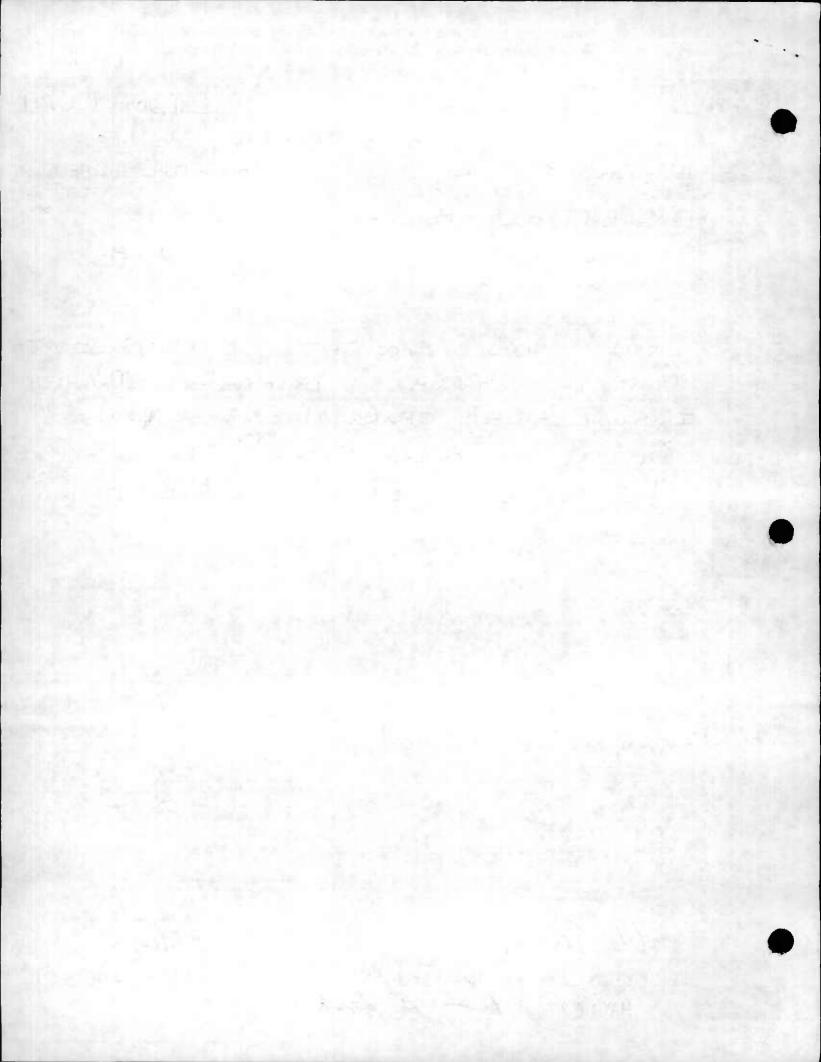
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32. Registrar's Signetura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland & Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Dafa of Death Dev Month **Physician** UZRALDINE GRIGALIUNAS May 08,2000 5:24 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Shock Trauma Center Baltimore If Under 1 Year | If Undar 24 Hrs. 9. Birthplece (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1□M 25 F Director 376 32 4125 Usual Rasidence of Decedent with the Marylend 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits rai", or items 23s or 28s-f shore Examiner must be notified at 1 ☐ Yas 2 No Director HARFORD MARYAM 10g. Citizan of What Country? 10e Street and Number 10f. Zip Coda ORIVS 11P 20PTHIA S.A. 21014 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, Whita, atc. Wes Decedant of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status filed within 72 hours efter 1 ☐ Nevar Married 2 ☑ Married 25 No Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: p 3 Widowed 4 Divorced Yaar or Datas: Tillew "netural", Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) TROC Avis 12YRS. UATE 5 Soci 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Peges 1 end 2 should be nent of Health end Mental HARROL MEMETH SCAFURI LARMILLA 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 21014 . permit. Pages 1 end 2 Department of Health 6 Important: If Item 27 Is any Injury or other tra ANTHONY GRIGALIUNAS 716 EOGEHILL DRIVE BEL AIR, 1 JARYLAND MAY 12, 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata cematery, crametory or other placa) 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata DECORD LANGER BLLRIR, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signature of Furnital S 22. Name and Addrass of Facility とくみへら Fしへを CHAPIL-BIL AiR, P.A. 21050 LASSAV newPORT DRIVE MARYLAD. FOREST HILL 23a. Part1. Enter the diseasa, or compile and the caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** NECK INJURIES /Medical Immediata Cause (Final disaasa or conditior rasulting in deeth) Examiner Due to (or as a consequance of): Examine sician end burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enfar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or es e consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of) 98 980 Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? 24b. Ware autopsy findings availabla prior to complation of ceusa of deeth? Completed The law page 2 yas 2□ No 2 No 25. Was cesa refarred to medical axeminar? Be 26. Placa of Death (Check only one) K¥Yas 2□ No Hospitel: 1 Marpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) edical Certification: To this 28a. Data of Injury (Month, Day Yaar) 27. Mennar of Death 28b. Tima of Injury P 28c. Injury at Work? 28d. Describe how injury occurred PASSENGER IN Attanding Division 1 Natural 5 Pending invastigation AUTO/AUTO IMPACT death. 5-7-00 1 Yas 2 No 9:15 2 X Accident Director: / 3 Suicide 6 Could not be 281. Location (Streat and Number or Rurel Route Number, City or Town, State) SOUTHBOUND I 95 NEAR MILE MARKER 91.8 CECIL CO 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
HIGHWAY 2 after 4 Homicide

P.O. of Vital

State Registrar

DHMH 16 Rev 6/95

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29b. Signature and fitte of certifier

29a. Cartifiar

32. Registrar's Signature

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30-Nama and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

MD

29d. Data signad (Month, Day, Year)

May 09,2000

1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, dete and piece, and due to the causa(s) and manner as stated.
2 **Theolical Examiner: On the basts of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated.

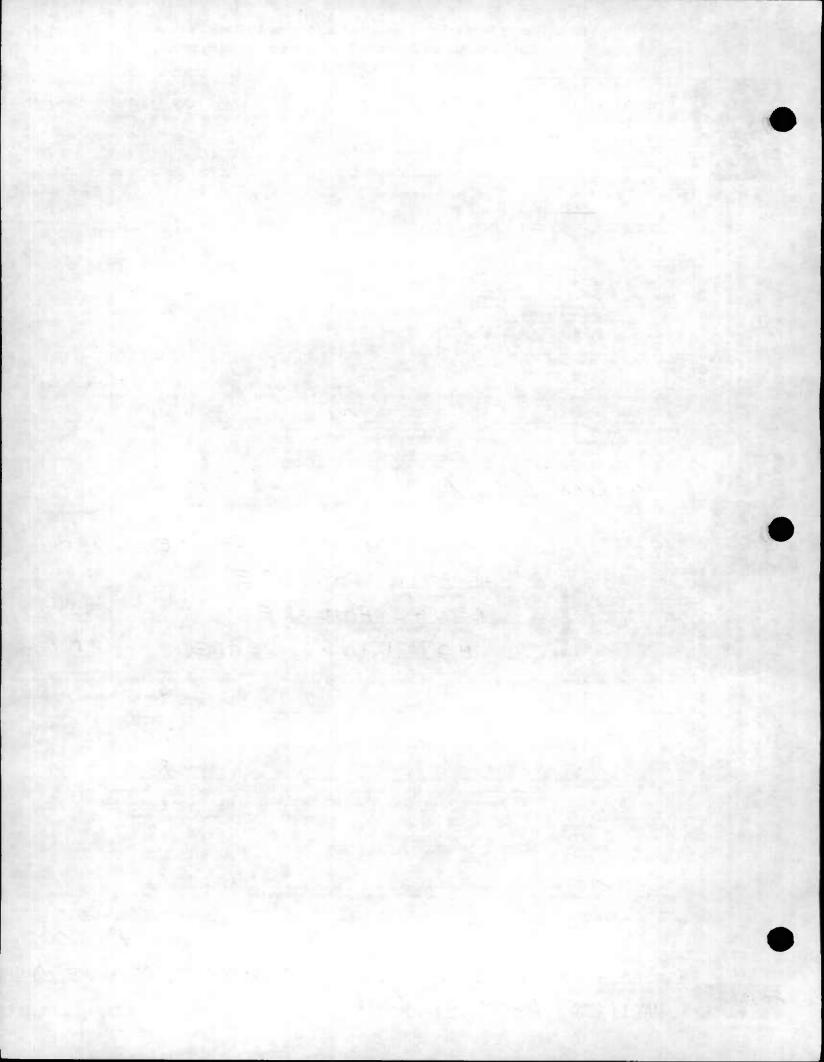
29c. Licansa number O.C.M.E.

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Physician	1. Decedent's Nama (First, Middla, LI THEODORE		NIIC	CD		2. Data of De Month	Day	Yaar 7:15 A	
/Medical Examiner Funeral	4a Facility Name (If not institution, gir		1012	1 2/6	4b. City, Town, or	MAY Location of Deat			
	GREENEBAUM CA		50					F BALTIMOI	
	5. Social Security Number 6.		s. last birthday) Yrs.	If Undar 1 Yaar Months Days				9. Birthplaca (Stata or Fora Country) New York	
irector	Usuel Residance of Decedant	27				11/13	11512	New TOTK	
W 18	10a. Stata 10b. County		10d. Insida City Limit						
to to	MD N/A	QUEEN ANNE'S C	rumptor	1			1 □ Yas X□		
or 28a-1 s be notified Director	10e. Street and Number			10f. Zip Coda		War.	10g. Citizen of Wh	net Country?	
	16 Andrews Lane			2162	8	300	U.S.A.		
al', or items 23s Examiner must by Funeral	11. Marital Status 1 □ Nevar Married 2€2 Married 3 □ Widowed 4 □ Divorced	Armed Forcas? 1 ☐ Nevar Married 2₹∑Married				Specify Yas or No to Rican, atc.)	lo- Black, Whita, atc. Specify: White		
lical feed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	oation	dia	16b. Kind of Bus	inass/industry	
t, the Medical	(Specify only highast gr Elementary/Secondary (0-12)	Collega (1-4or 5+)		edent's Usual Occupation e kind of work dona during most of working DO NOT usa ratired)					
	12		Truc	k Driver				mployed	
B son	17. Father's Nama (First, Middla, Las	0					, Maidan Sumama, iler Inc		
To	David Grigonis				6224 E	astern A	ve. Balt:	imore, MD. 2	
Is m	19a. Informant's Name/Ralationship	(Type, Print)		ng Address (Streat				Stata, Zip Coda)	
Pag 27	David Grigonis	loo:		Box 234	Easton, l				
9 16	20e. Method of Disposition 1 □XBurial 2 □ Cramation 3 □		cematary, cra	osition (Nama of matory or othar ple	ca)	Date	20c. Location - C	City or Town, Stata	
ant ary	4 □ Domation 5 □ Other (Speci		acred H	leart Cem	etery	5/11/00	Cutchogu	ue NY.	
N in	21. Signature of Funaral Sarvice Lice	nsee /		2. Nama and Addra					
1588	Merabeth	Selent	1 62	24 Easte:	rn Ave. 1	Baltimor	e, Maryla	and 21224	
	23a. Part1. Enter the diseasa, or con shock, or heart tailure. List only	plications that caused tha da	ath. Do not an	tar tha moda of dyi	ng, such as cardia	c or raspiratory a	rrast,	Approximata Interval Between	
/sician	snock, or neart tailure. List only	one ceuse on aach lina.						Onsat and Death	
ledical	Immediata Causa (Finel diseasa or condition CARDIO RESPIRATORY FAILURE								
aminer	diseasa or condition rasulting in death) a. CARDIO RESPIRATORY FAILURE 15 Dua to (or as a consequence of):								
ĕ			TIC	- 0	ILUR	_		7- DAYS	
in and ial-transit Examiner	Sequentially list conditions	U	(or as a consa		1000			1 211	
an and rial-tra	Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Disaasa or Injury that initiated events	-		3 DAY 0					
physician s the buris edical E	Cause (Disaasa or Injury that initiated events	,		0 21. [2					
CD 68	rasulting in death) Last	= ACF	EASE 9 MG						
CD 68		d. H '.	HODGKINS DISE					9 MONT	
use use					van in Part I	23b. Did	tobacco use cont	ributs to the cause of dea	
e attending od for use a siclan/M	Part II. Other stanificant conditions	contributing to death but not re	sulting in the !!	indarlying causa di					
by the attendir tached for use thysiclan/A	Part II. Other significant conditions of	contributing to death but not re	sulting in tha u	indarlying causa gi	an ar area.	10	Yes STANO :	3 Probably 4 Unkn	
ned by the attendire detached for use	Part II. Other eignificant conditions of	contributing to death but not re	sulting in tha u	indarlying causa gi		10	Yes 2 No :	3 Probably 4 Unkn	
in signed by the attendir uid be detached for use and by Physician/A	Part II. Other significant conditions of	contributing to death but not re	sulting in tha u	indarlying causa gi		24a. Was	an autopsy	24b. Were eutopsy finding	
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Goodrich 2000 :500 0 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bultwore Johns Hopkins Genetrics Onte 8. Date of Birth (Month, Day, Year) If Under 1 Year Months | Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1□M 2EXF Min 88 220-22-3897 Director 1912 Ohio Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 ☐ No Director MD Baltimore Rosedale 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ĕ 23 9312 Beowulf Cr. 21237 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give or items 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. rrt: if Item 27 is marked other than "natural", or ite 1 Never Merried 2 Married 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 Charles Waller Thigpen Marguerite Samantha Davis 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health i Hem 27 h r other tra Margaret Rommel 9312 Beowulf Cr. Baltimore, Maryland 21237 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Department of Important: If II any injury or o 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) of Faith Cemetery 5/13/00 Baltimore, Maryland Gardens uvice Licenses 21. Signeture of Funeral 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical hypercomolor non-lattic como Examiner Due to (or as a consequence of): Physician/Medical Examiner diabetes use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dementa signed t p Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 1 ☐ Yes > No 1 Yes 2 No certificate Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred After Naturel 5 Pending investigetion 1 Yes 2 No 2 Accident

Box 68760. P.O. Division of Vital Records,

the Maryland

Saltimore, Maryland 21215-0020

Attending Physician: The law requires that the death certificate be executed

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A filled in by

completely

edicai

State Registrar

6 Could not be determined

3 ☐ SuicIde

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture eppt title of certifier

29c. License number 38679

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29d. Date signed (Month, Day, Year)

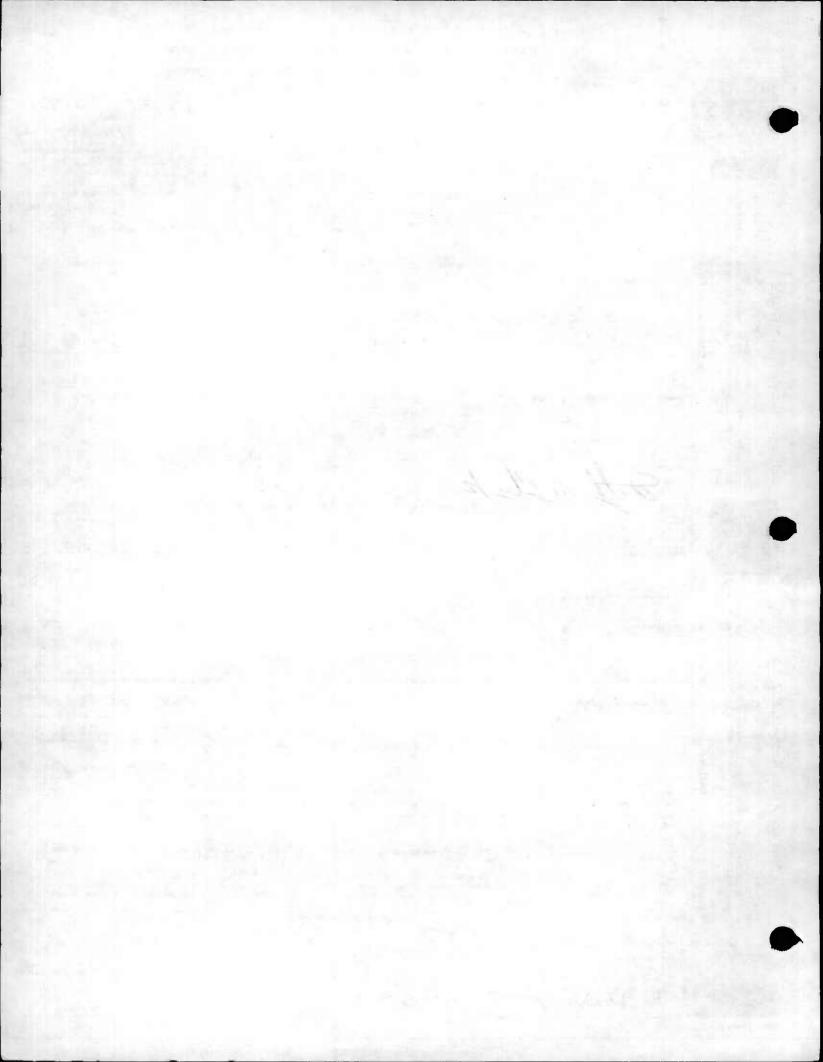
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fredman San 32 Registrer's Signature

940 Eastorn Ane

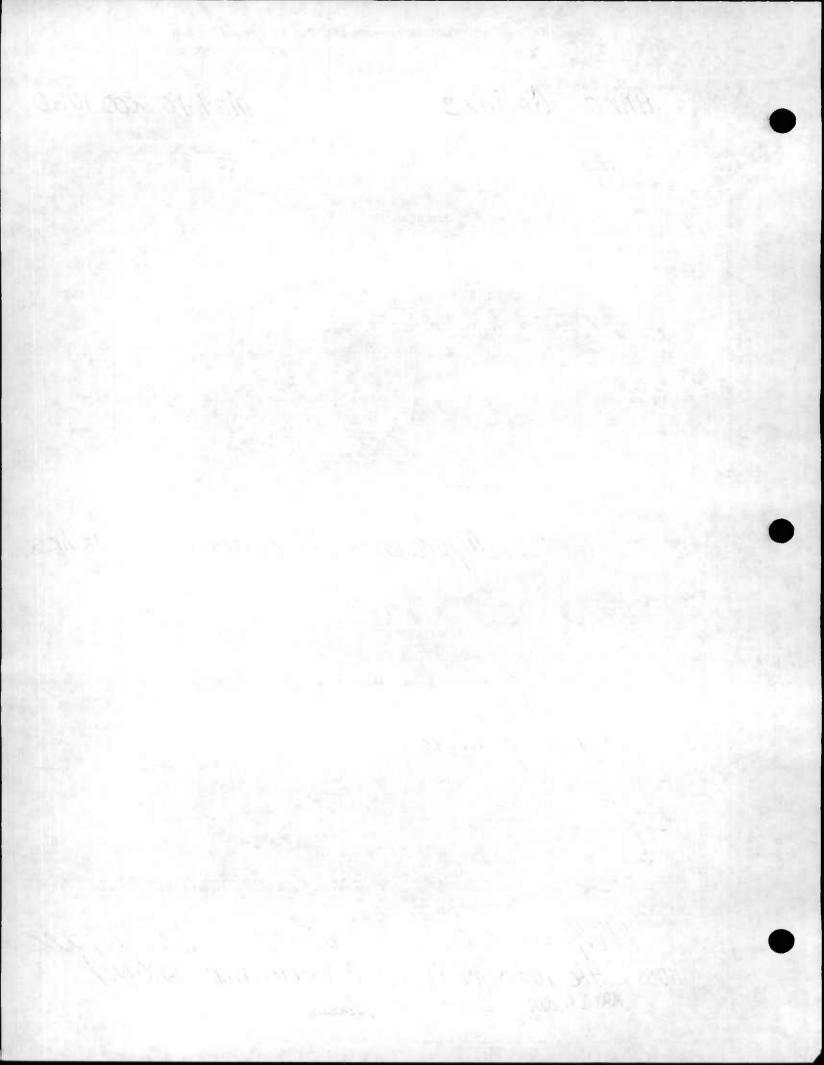
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Certificate of Death	Reg. No.) 10017							
nysician Medical	1. Decedent's Name (First, Middle, Last) (C/inas	2. Date of Death Whith Pey	2000 1030							
xaminer	4a Facility Name (If not institution, give street and number) 4b. City, Town Howard County General Hospital Column	bia Ho	nty of Deeth Ward							
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthday) 1 Under 1 Yeer If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Year) June 11, 190	9. Birthplace (State or Foreign Country) 7 New Hampshire							
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									
at, or items 23s or 28s-f show Examiner must be notified at by Funeral Director			10d. Inside City Limits 1 ☐ Yes XX No							
	MD Anne Arundel Sherwood Forest 10e. Street and Number 10ff. Zip Code	10- 00								
	10e. Street and Number 10f. Zip Code 117A Edge Hill 21405		of What Country?							
Š	11. Maritel Stetus 1 □ Never Merried 2 □ Married 2 □ Married 3 □ Was Decedent Ever in U,S. Armed Forces? 1 □ Yes ② No If Yes, specify Cuben, Mexican, For Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin If Yes, specify Cuben, Mexican, For Yes, Give Year or Dates:		Race - American Indian, Black, White, etc. City: White							
Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most o	f working	Business/Industry							
npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	WOIKING								
S	3 Teacher/Librarian	Educa								
To Be	Eliman Balance	s Name <i>(First, Middl</i> e, <i>Maiden Surr</i> a. Dow	ame)							
	19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of	or Rural Route Number, City or To	wn, State, Zip Code)							
	Ann L. Jubb (Daughter) 117A Edge Hill, She	erwood Forest, M	D 21405							
	20a. Method of Disposition 1 Burial 2 Cemetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Placa of Disposition (Name of cemetery, crematory or other place) Metro Crematory	05/13/	imore, MD							
es the burial-transit a p or or or or or or or or or or or or or	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as calculated the deeth. Do not enter the disculated the deeth. Do no	enue, Annapolis,	MD 21401 Approximate Intervel Between Onset and Death // A hrs.							
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
200	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use	contribute to the cause of death?							
y Physician	Dubotes	The second secon								
Completed by	Renal Jailure	24a. Was an autopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death?							
Sol		1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No							
Be (25. Was case referred to medical examiner?	f Death (Check only one)								
To	Hospital:	ing Home 5 ☐ Residence 6 ☐	Other (Specify)							
To the Funeral Director: Affer this completely filled in by the funeral di Medical Certification: To	27. Menner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigetion 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28b. Time of injury 4 Work? 1 ☐ Yes 2 ☐ No.	28d. Describe how injury oc	curred							
	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Nu City or Town, Stete)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)							
edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and a control of the basis of examination and/or investigation, in my opinion, deeth one)	place, and due to the cause(s) and occurred et the time, dete and ple	menner as stated. ce, and due to the ceuse(s)							
N	one) end manner stated. 29c. License number	29d. Date sid	gned (Month, Day, Year)							
	> ////2/M.D. D507	78 Mac	N 10, 2000							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1055 4/THE FATUXONT PRUM COLUMBIT	4, mo 21	044							
State gistrar	31. Date filed (Month, Cey, Year) 32. Registrar's Signeture									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** Michael E. Groves 2000 1400 May /Medical 4e Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Deeth 4c. County of Death Examiner Prince Georges Hospital Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Yeer) March 19,1966 Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthdey) **Funeral** Deys Months Hours tXDM 2□F 216-96-2287 34 Yrs Director New York Usual Rasidance of Decedant deeth with the Marylend 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits ahow permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryle Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itams 23s or 28s-1 ahor any injury or other traumetic event, the Magical Examinal must be notified at 1 Yes ZENo Director Prince Georges Bowie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12033 Twin Cedar Lane 20715 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1X Never Married 2 Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Photographer Photography 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be Max E. Groves Sally J. Turner 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Max E. Groves (Father) 12033 Twin Cedar Lane, Bowie, MD 20715 20b. Plece of Disposition (Nema of camatary, cremetory or other pleca) Data 20e. Method of Disposition 20c. Location - City or Town, Stata 05/13 MXBuriel 2 ☐ Cremetion 3 ☐ Ramoval from State Stephens Church Cem. 4 ☐ Donetion 5 ☐ Othar (Specify) 2000 Crownsville, MD 21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility Hardesty Funeral Home, P.A. ulla 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Batwean Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner attending physician and for use es the bunal-transit certificate be executed Sequentielly list conditions, if eny, leeding to immadiate cause. Entar Undarlying Ceuse (Disease or Injury that initieted events resulting In deeth) Last Due to (or es e consequenca of): P.O. Box 68760. Physician/Medical Due to (or es e consequença of) ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were eutopsy findings evallable prior to completion of cause of death? should l 24e. Wes en eutopsy Completed page 2 s has 2 No 1 ☐ Yes 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Diractor: After this certifica director Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminar? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No Unpatient 2 ER/Outpetient 3 DOA funeral 28c. Injury et Work? 27. Marmer of Deeth Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurrad Certification: 5 Pending invastigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rure! Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicida 24 hours Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, data end place, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On the bests of exemination end/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to the causa(s) end mannar stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier edical (Check only one) 29c. License number 29d, Date/signed (Month, Dev. Yeer) 29b. Signeture end title of certifier 4 e 30. Name end eddress of person who complated causa of death (Itam 23e) (Typa, Print) James Catavenis, MD, 3001 Hospital Drive, Cheverly, MD 20785 31. Deta filed (Month, Day, Year) 32. Registrer's Signature State MAY 16 Registrar

DHMH 16 Ray 6/95

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Be

nicion	Decedent's Name (First, Middle, Last)								2. Date of De	_	_ Year	3. Time of Death
sician edical	Beverly Jean Gilmore								Month May	Pay	2000	11:35 A.N
miner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Lo											
1	5. Social Security Numb		Green Or	7. Age (In yrs.	-	If Under 1 Year	Glen				e Aru	
	216-60-685	56	1□ M 2⊠F	46	Yrs.	Months Days		Min.	8. Date of Birt (Month, De April	y. Yeer) 5, 1954		lace (State or Foreigr try) yland
	Usuat Residence of Dec 10a. Stete 10	b. County		10c. Ci	ty, Town or Lo	cation			167116		11	0d. Inside City Limits
river rust be notified at Funeral Director	MD Z	Anne A	rundel	G1	en Bur	nie						1 □ Yes 🍇 No
	10e. Street and Number					10f. Zip Code	- 47		0	10g. Citizen of 1	What Coun	try?
	8069 Green	Orcha	ard #1			2106	1			USA		
	11. Maritel Stetus 1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Fo	2 No	t	Vas Decedent of I I Yes, specify Cub	an, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)		ce - Americ ck, White, o y: Wh.	
	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done duning most of work interesting) 16b. Do NOT use retired)						t of workir	ng	16b. Kind of B	usiness/Ind	dustry	
	Elementary/Seconde	ry (0-12)	College (1-4or 5+)		ing Assi	12.			Hospita	al	
	17. Father's Name (Firs	t, Middle, Las	st)					r's Name	(First, Middle,	Maiden Sumen		
	Emmett A.	Tyding	gs, Sr.			The Gray	Ma	ary A	. Wood			
	19e. Informent's Name.	Relationship			13 A. C.	g Address (Stree	t end Numbe	er or Rure	I Route Numbe	er, City or Town,	Stete, Zip	Code)
i	Emmett A.		gs, Jr.	(Brothe		30 Parke	y Road					
	20a. Method of Disposit XX Buriai 2 Co 4 Donation 5	remetion 3		State	cametery, cren	sition (Name of natory or other pla oln Ceme			5/16 2000	Brentwo		
	21. Signeture of Funera	I Septice Lig	151	Em	1	Name and Addr Hardesty 12 Ridge	Funer	al H			2140	01
	23a. Pert1. Enter the d shock, or heart fei Immediate Causa (Fine disease or condition resulting in death)		a		CARDIA (C ARRHYTH	HMIA				1	Onset and Death
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE												
al Evallille	Sequentially list conditi if any, leading to immer cause. Enter Underlyin cause (Disease or Injur- that initiated events	ons, diate	Due to (or es a consequenca of):									
Physician/Medical	resulting in death) Last	l	d	Due to (or as e consequence of): d								
	Part II. Other elgnifican	t conditions	contributing to de	eath but not res	sulting in the ur	derlying cause of	iven in Part I		23b Did	lobacco usa co	ntribute to	the cause of death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATIC STEATOSIS						1 🗆	1		pably 4 Unknow		
									24a. Was perfo	en eutopsy med?	ave	ere autopsy findings silable prior to mpletion of cause deeth?
	Section 1								12	Yes 2□No	i	Yes 2 No
e n	25. Was case referred t	to medical						of Deeth	(Check only o	one)		
2	1 No 2 No	-12	1		ER/Outpatien	1 3LI DOA				dence 6 Oth		y)
oci micano	1 to Natural 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No							28d. Describe	now injury occur	rred		
-	3 ☐ Suicide 6 4 ☐ Homicide	Could not determine	d 200. Plece	8e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)			2	28f. Location (: City or To	Street and Numi vn, Stete)	per or Rure	I Route Number,	
edicai			miner: On the b			occurred at the ti restigation, in my						
žΙ	29b. Signeture end title	of certifie	1	11		29c. Licen	se number		29d. Date signed		ed (Month,	Day, Year)
		16	11/1	14/			C.M.	E.		May	12,	2000
		A	14/11	10						1107		

Committee of the second second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Ida M. Garber /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MORE
If Undar 24 Hrs.
Hours Min.
JUNE 11, N/A HOSPITAL 7. Aga (In yrs. last birthday) 79 Yrs. If Undar 1 Yaar 5. Social Security Number 218-10-5748 Birthplaca (State or Foreign Country) **Funeral** Days Year) 1□ M 3□ F Director 1920 Marvland Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits notified at Maryland Anne Arundel Glen Burnie 1 ☐ Yas X ☐ No Director 288-1 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 8 1807 Norfolk Road 21061 USA ma 23a Funeral death 11. Marital Status 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Baca - American Indian Black, Whita, atc. 'netural', or Iten filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No Baltimore, Maryland 21215-0020 1 ☐ Yas 2√ No Specify: Specify: Be Completed by 3 Widowed 4 Divorced White 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) 12 Manicurist Self-employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked ofth any Injury or other treumstic event DOEs. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Joseph Sewell Emma Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Raymond J. Garber/Husband 1807 Norfolk Rd. Glen Burnie, MD 20b. Placa of Disposition (Nama of 20e. Method of Disposition 20c. Location - City or Town, State MD Vererans o'Celletery/ 1 Burial 2 □ Cramation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville 5/16/00 Crownsville, MD 22. Name end Address of Facility
MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Lipenses Thomas Gregor 301 Frederick Road Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediata Causa (Final disaase or condition rasulting In death) /Medical Examiner Dua to (or as a consequenca of): Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Dua to (or as a/consequanca of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No à 24b. Wara autopsy findings evellebla prior to Be Completed 24a. Was an autopsy performed? ROIDI complation of causa of death? 1 Yas 2 No 1 TYAS 2 No. 25. Was casa refarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yes 2 No edical Certification: To 럂 Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 5 Panding invastigation After Natural 1 ☐ Yas 2 ☐ No 2 Accidant after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide b within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian (Check only one) 2 29b. Signetura end titla of certifiar 29d. Data signed (Month, Day, Year) male 2000 30. Name end addrass of person who complated causa of death (Item 23a) (Type, Print)

ANNA KORZAN STAGNES 900 CATION HEALTHCARE KORZAN mp 21229 BAUTIMORE 31. Date filed (Month, Day, Year) MAY 15 2000 32. Registrar's Signatura State Registrar DHMH 16 Rev 6/95

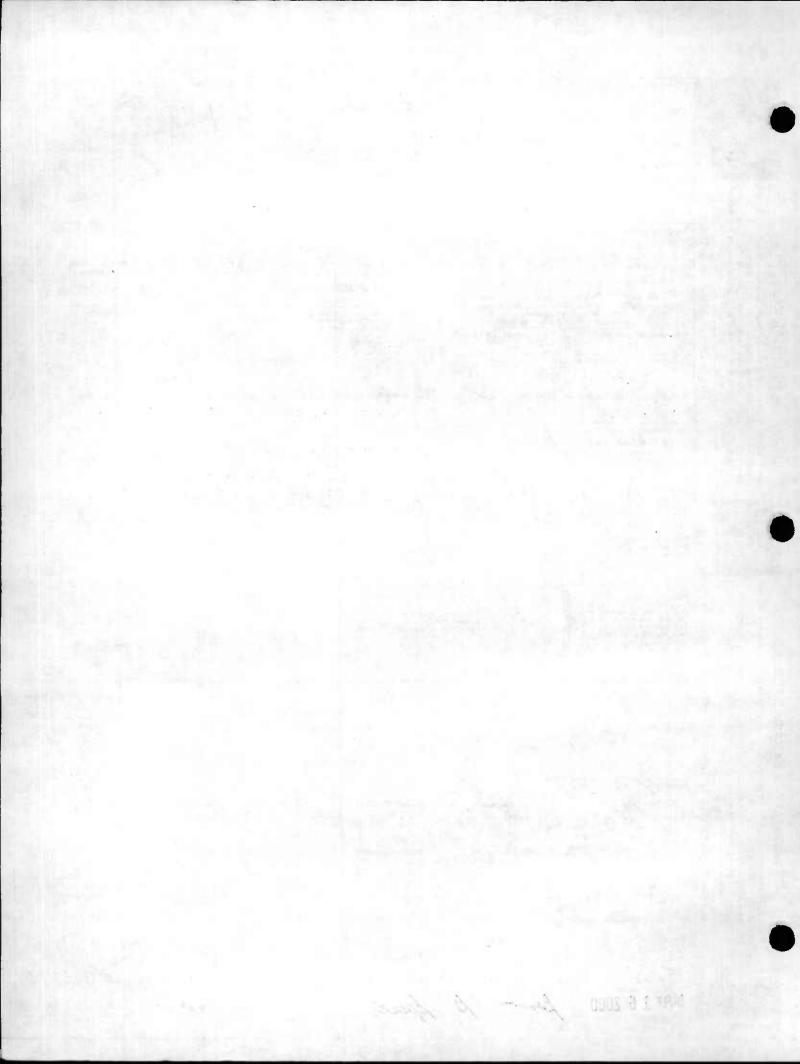
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_	Decedent's Nama (First, Middle, Las	State of Maryla		tificate of			Reg. No.	100	J. Tima of Death
Physician /Medical	Gordon 4a Facility Nama (If not institution, give		Ha	mrick	4b. City, Town, or I	May	12 2	2000 I	19:15
Examiner Funeral	Bathmore VA 5. Social Security Number 6. Se	Medical Ce	enter s. last birthday)	If Under 1 Year Months Days	Battim	ore 1		n/a 9. Birthplace	a (Stata or Foraign
Director	Usual Rasidence of Decedent 10a. Stata 10b. County		6 Yrs.	ation		July 1	0,1923	West	rginia Inside City Limits
er death with the Maryin thems 23e or 28e-f shor one must be notified at unneral Director	MD Balti	more		M:	iddle Riv				
s 23s or 3 nust be n or al Dir	804 Maple	Crest Drive			21220			USA	
Exame	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? XIX Yes 2 No if Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes or Not 1998) types, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 No Specify:			o- 14. Race - Amarican Indian, Black, Whita, etc. Specify: White		
within 72 ans. than 'nat he Medic	15. Decedent's Edi (Specify only highast grad Elamantary/Secondary (0-12) 12th	cation (a completed) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Inspector			16b. Kind of Business/Industry National Wire		
B start	17. Fathar's Nama (First, Middla, Last)				18. Mother's Nan			na)	
marke marke marke	Verden Hamric 19a. Informant's Name/Relationship (7)		10h Mailine	Addrage (Street	and Number or Ru		Cogar	State Zin Co	dal
and 2 sho waith and n 27 is me er traum	Merlin M. Hamrick				rest Driv		imore Mo		1
Pages 1 a nent of He nit: If Hern rry or othe	20a. Mathod of Disposition 1 □ Burial 2型 Cremation 3 □ t 4 □ Donation 5 □ Other (Specify,	Removal from State		ition (Name of atory or other place ematory		Date .5/2000	20c. Location -	City or Town,	
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be d		U, g.				24a. Was	Yes 2□ No an autopsy	24b. Wara	autopsy findings
has b			7.9			10			ation of causa th?
ysician: The secretificate director, peg	25. Was casa refarred to medical examiner?				26. Place of Dea	ith (Check only o	4		
After this funeral di	1 ☐ Yas 2 ☐ No 27. Mannar of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident invastigation	28a. Date of Injury (Month, Day Year)	1) Inpatient 2 ER/Outpatient 3 DOA 4 Nursing H			oma 5 ☐ Rasidence 6 ☐ Othar (Specify) 28d. Describe how injury occurred			
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he Hospital in 24 hours a he Funeral I pletely filled edical Ce	29a. Cartifier Certifying Physics (Check only one)	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death on nation and/or inve	occurred at the tire estigation, in my o	ne, date and place pinion, death occu	, and dua to the rred at the tima,	cause(s) and me data and place,	annar as state and due to the	d. a cause(s)
To the within 7 To the comple	29b. Signatura and littinol certifier	. ^		29c. Licens			29d. Data signe		
	30. Nama and address of person who co	ompleted cause of death (No	em 23a) (Tvoe. P	P12	2417		11/ay 1.	2,20	00
State Registrar	Jean R. Hou 31 Data filed (Month, Day, Year) MAY 1 6 2000	22 South C	reene S	treet.	2417 Departme	nt of A	redicine	e, Balt	imore, 1.

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month 5 **Physician** 5 2000 9:45 a.m. ISC /Medical 4a Facility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore St Joseph Hospital If Under 1 Year | If Under 24 Hrs. Data of Birth (Month, Day, Year) 9-20-1949 Birthplaca (State or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 M & TYF 214-56-3115 Yrs. Md Director 50 Usual Rasidence of Decedant the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at 1 Yas 2 □ No Director Balto Md Abington 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with 343 Delmar Court SA 21209 IJ Funeral 14. Raca - American Indian, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturelt, or the any injury or other traumatic event. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Navar Married XX Married Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Northrop Administrative Assistant 12th grade Grumman N/A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Hunter Richard Marie Alston 19a. Informent's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) James S. Holman-Husband 343 Delmar Court Abington, Md 21209 altimore, 20b. Place of Disposition (Nama of camatary, cramatory or other placa)
Woodlawn Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stata 1√ Burial 2 Cremation 3 Ramoval from Stata 4 Donetion 5 Othar (Specify) 5-10-00 Baltimore, Md 22. Nama and Address of Fecility
March F/H West I Funaral Sarvice Licens Wabash Avenue Baltimore, Md 21215 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata interval Betwaen Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition resulting in deeth) /Medical elle Mvo dave Examiner Examiner certificate be executed physician end s the buriel-transit Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Dua to (or es a consequence Records, P.O. Box 68760 Physician/Medical that initiated avants Due to (or as a consequence of): rasulting in death) Last Se esn ettending Po ed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t þ cete has been sign, page 2 should b 24b. Wara autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy certificete has 1 ☐ Yes 2 No 1 Yas 2 No Division of Vital Attending Physician: director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) axaminar? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No After this 28c. Injury at Work? 27. Mannar of Death 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Matural - Hospital or Ab.

*Qurs after death.

* Director: A.

* No. 19/ 1 Yas 2 No 2 Accident 6 Could not ba detarmined 3 Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 ☐ Homlcide withing4 hours a Forthal Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addr

State

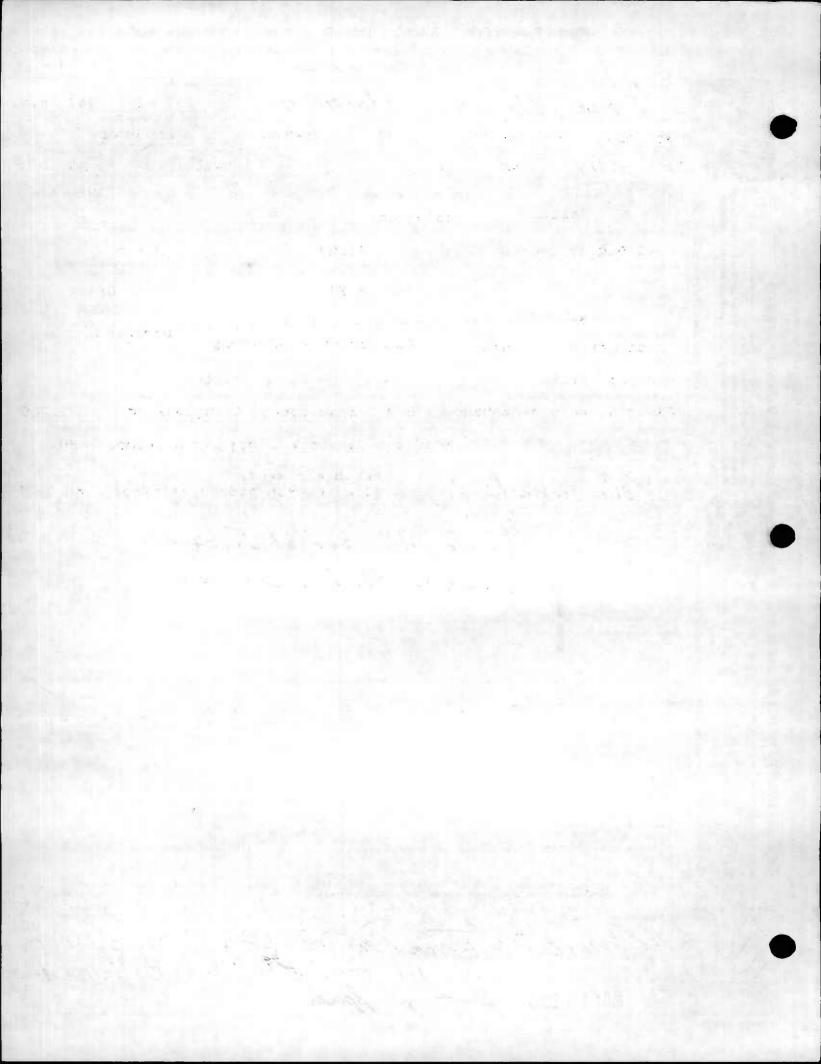
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32. Registrer's Signature

31. Data fited (Mo



00-2555-047 jhm KINKE A	Please Type or Print in Blac State of Maryland /	Department of Health and I		egible.		
HOLDEN JR	AMEND ITEMS: #23 PART I, 27 PER MEO	Certificate of Death	Reg. No.	10 10020		
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/Medical	KINTE' Ahma Holde		MAY 06, 200	0 06:44 AM		
Examiner	4e Facility Name (If not institution, give street end number)	4b. City, Town, or	Location of Death 4c. C	County of Death		
3/2	500 BONNEVILLE AVENUE 5. Social Security Number 6. Sex 7. Age (In yrs. last by	POCOMOKE		ORCHESTER		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)		
	Usual Residence of Decedent	D	04-05-4-			
deelh with the Maryland rms 23a or 28s-f show r.must be notified at neral Director	1 110 111	wn or Location		10d. fnslde City Limits		
the Maryle 28s-f sho notified at	MD WORCESTER POC		1 ☑ Yes 2 □ No			
ifier deeth with the Ma ifier 23a or 28e-fa ifier must be notified Funeral Director	10a. Street and Number	10f. Zip Code 21851	10g. Citize	en of What Country?		
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Fune	11. Merital Stefus 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No	13. Wes Decedent of Hispehic Origin? (S ff Yes, specify Cuban, Mexican, Puert				
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Department of I important: If its any injury or o pace.	4 Donetion 5 Other (Specify) 21. Signefure of Funeral Service Licensee	22. Name and Address of Facility	5-12.00 Poca	moke, MD		
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be detached for use by Physician/N	Pert fl. Other afgnificant conditions confributing to death but not resulting	23b. Did tobacco usa contribute to the cause of death?				
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			24e. Wes an autops	y 24b. Were autopsy findings		
page 2 should			performed?	eveileble prior to completion of cause of death?		
ege			1 Yes 2□	No 116 Yes 2□ No		
director, page	25. Was cese referred to medical	ath (Check only one)				
To E	examiner? Yall Yes 2 No Hospital: 1 Inpatient 2 ER/C	Other		Other (Specify) SCENE		
h. Afferthis funerel di tion: To	27. Menner of Deeth 28e. Dete of Injury 28b.	28d. Describe how injury occurred				
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within 24 hours all or Attending within 24 hours all of eath. To the Funeral Director: After completely filled in by the fune Medical Certification	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or Rurel Route Number, City or Town, State)			
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completely filled in by the funeral Medical Certification:	29a. Certifier (Check only open of the basis of examination a control on the basis of examination a control on the basis of examination a control on the basis of examination a control of the basis of examination a control of the basis of examination a control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the control of the basis of examination and the control of t	ge, death occurred at the time, date and plece nd/or investigation, in my opinion, death occu	, end due to the cause(s) a rred et the time, date and p	and manner as stated. Diece, end due to the ceuse(s)		
Med Wed	one) X end menner steted. 29b. Signature and title of certifier	29c. License number		signed (Month, Dey, Year)		
2 8		OCME				
	JAII. OT		MAY	07, 2000		
	30. Name and eddress of persoft who completed cause of deeth (Item 23a					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician Don Henry Hoffeld May 12, 2000 8:20 am /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Greater Baltimore Medical Center Towson
If Under 24 Hrs. Baltimore if Under 1 6. Sex 1 M 2 □ F 8. Date of Birth (Month Day Year) May 05, 1913 9. Birthplece (State or Foreign Country) Cincinnati, Ohio 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 288-01-4257 87 Director Usual Residence of Decedent the Meryland 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mertal Hygiena. Improment if the 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examine must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Co. Lutherville Director 10a. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 9 Knightingale Way United States of America Apt.#A6 21093 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: White Specify: þ 3 N Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) offeld, Elementary/Secondary (0-12) College (1-4or 5+) National Sales Manager Eastern Products Corp. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Harry Hoffeld Luise Spiedel 2 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Mrs. Carol Whiteford(Daughter) 8307 Alston Road Towson, Maryland 21204 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Hilltop Service Corporation 5/15/2000 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. at Service License Inffrey L. Gair an 1050 York Rd. Towson, Md. 21204 ter the disagn Approximate Interval Between Onset end Deeth ns thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical 10 minutes a Cardiorespiratory failure Examiner Due to (or es e consequence of): Physician/Medical Examiner Abscess, right lower lobe of lung several days physician and s the burial-transit cartificata be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): P.O. Box 68760 Pneumonia, bilateral lungs several days that initiated events resulting in death) Last Due to (or as e consequence of): 88 attending for usa as The lew requires that the death signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 Yes 2X No Records, by 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was en eutopsy hes a 2 s certificeta hed 1 Ñ Yes 2 □ No 1 N Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours eftar death. Funeral Director: Attar this certifice director, 25. Was cese referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funaral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 (X)Natural 1 ☐ Yes 2 ☐ No 2 Acciden rector: 3 Suicide 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner stated. 29a. Certifier edical 29d. Dete signed (Month, Dev. Year) 29b. Signature end title of certifie 29c. License number 05/13/2000 D38352 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) GBMC 6701 N Charles St., Baltimore MD 21204 Beth R. Schwartz, M.D.

DHMH 16 Rev 6/95

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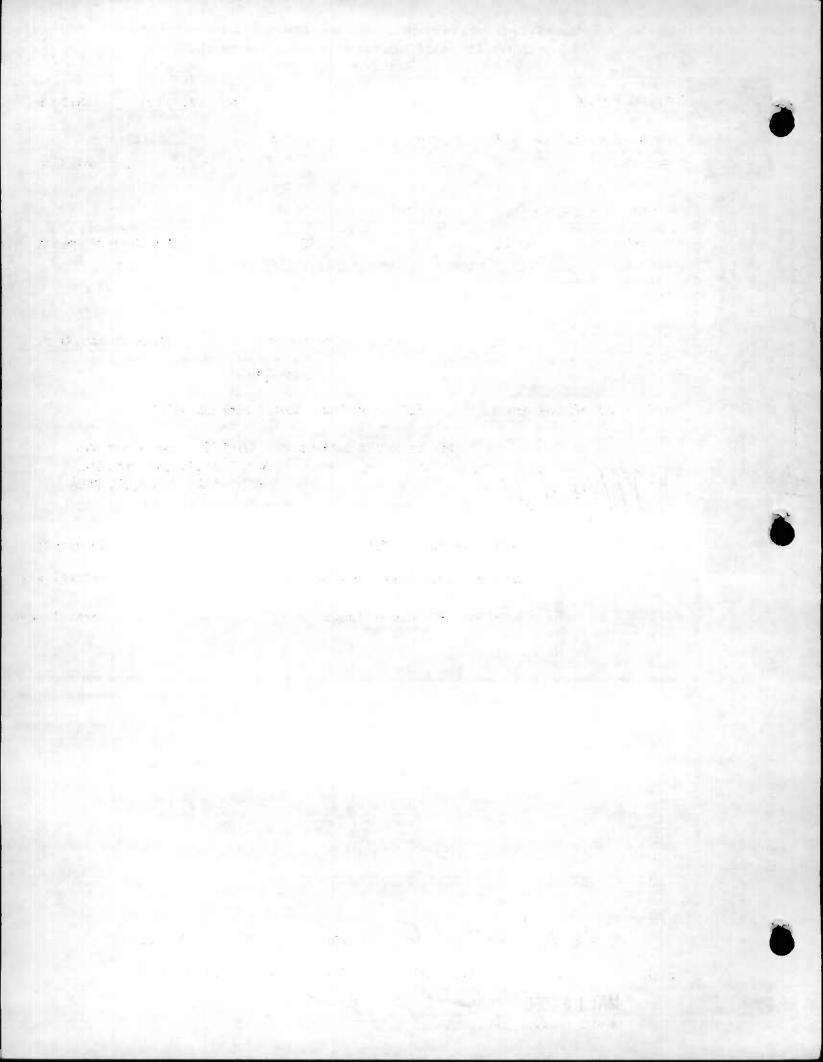
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32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 6 2 2 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Death 3. Time of Death 12, **Physician** Month 8:20 A.M. May 2000 Lambert Wilfred Hardesty /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 912 Starbit Road Towson Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth Month, Day, Year) July 15, 1921 9. Birthplace (Stata or Foreign Country)
Davidsonville, Md. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20 F Yrs. 78 Director 215-16-5820 Usuat Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Medical Examinar must be notified as 1 Yas 2 No Director Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Starbit Road 21286 U.S.A. Funeral 12. Wea Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give W.W.II 14. Race - American Indien, Black, Whita, atc. "natural", or items Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hyglene. Important: if Itam 27 ie marked other than "natural", or iten eny injury or other traumatic event, the Medical Examinat 1 Never Merried 2 Merried 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dept. of Corrections Baitimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Lambert L. Hardesty Agnes V. Steiner 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Evelyn Hardesty/Wife 912 Starbit Road Towson, Maryland 21286 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriat 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 5/15/00 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Entar the disease, of complications the Jaure of the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only one cause of each line. Approximete tntarval Between Onset and Death **Physician** fmmediate Cause (Finel disease or condition resulting in death) /Medical · Cerebrovascular Accident lucek Examiner Examiner 30 years Fibri Ittrial attending physician and d for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or es a consequence of) Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown alon 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? 1 Yea 2 No 1 Yea 2 No certificate Hospital or Attending Physicien:
 24 hours efter deeth.
 Funeral Director: After this certifica director. 25. Was case refarred to medical Be 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1) Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, end dua to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end dua to the ceusa(s) and manner steted. 29a. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04027 May 12,2000 on MD 5601 Loch Raven Blud, Baltimore 21239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Wilson MD 31. Date filed (Month, Day, Year) State MAY 1 6 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 15 **Physician** FREDERICK BARTON HARVEY JR. MAY 2000 8:30AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2 LINDSAY LANE BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 06/22/1921 Birthplace (Steta or Foreign Country)
 MARYLAND 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 105M 2□ F 216-16-6194 78 Yrs. Director Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ltems 23s or 28s-f show 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 LINDSAY LANE 21212 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amaricen Indien, Bleck, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or his any injury or other traumatic event, the Medical Examination. 1 Yas 2 No If Yes, Giva Year or Datas: 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) Elamantary/Secondery (0-12) College (1-4or 5+) INVESTMENT BANKING BANKING 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) 8 FREDERICK BARTON HARVEY ROSE HOPKINS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) FREDERICK B. HARVEY III(SON) 3 MIDVALE RD. BALTO., MD. 21210. 20b. Plece of Disposition (Nama of cematary, crematory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Buriel 2 Cramation 3 ☐ Ramoval from Stata NICHE-CH. OF THE REDEEMERO5/17/2000 BALTO., MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licensea 22. Nama and Addrass of Facilit HENRY W. JENKINS & SONS CO. alexIII 4905 YORK RD. BALTO., MD. Approximate Intervel Between Onsat and Death 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disaasa or condition rasulting in death) Parknin's years **Examiner** Dua to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laeding to immadiata ceuse. Entar Undarlying Cause (Disease or injury Due to (or es a consequence of): nding physician use as the burial Box 68760 that initieted evants rasulting in daath) Last Due to (or as a consaguance of): for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Orthostahe potensim Records, à 24b. Ware eutopsy findings available prior to completion of ceuse of deeth? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 Ø No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa rafarrad to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Naturai 5 Panding invastigation 1 ☐ Yas 2 ☐ No death. Hospital or Attandi
 24 hours after death
 Funeral Director: / 2 Accidant 6 Could not be datarmined 3 Suicide 28a. Place of Injury - Al homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) completely filled in by 4 Homicida 29e. Certifiar (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. within 2 To the ş 29b. Signeture end titia of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) M.D. D51789 5/15/00 30. Name end addrass of person who completed cause of daeth (Itam 23a) (Type, Print) 6565 N. CHARLES ST. BACTO, MI MATTHEW GORDON MEIDORF

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31. Data filed (Month, Day, Year) MAY 1 6

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** HAWKINS May AMUEL 2000 5:16 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince George's Hospital Laurel _aurel If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Mar 1, 1946 5. Social Security Number Birthplece (Stete or Foreign Country)
 DC 7. Age (In yrs. last birthdey) **Funeral** Months Days Yrs 54 Mar Director Usuel Residence of Decedent 10a. State with the Marylend Prince Georges 10d. Inside City Limits 10c. City, Town or Location parma. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiene. Important if them 27 is marked other than "naturel; or items 23e or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at Laurel 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9001 Cherry Lane 20708 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Pace - American Indien. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Samuel B. Hawkins Sr. Martha L. Jones 0 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Martha Thomas/mother unk 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in State ignature of Europai Service Licenses Ande 25 Late Anatomy Board Director 655 W. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death hart1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Vanowa **Examiner** Due to (or as a consequence of): Examiner sician end buriel-transit The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, inding physician use as tha burie Physician/Medical Due to (or as a consequence of) signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificate has b director, pege 2 s 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 12 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1. Natural 5 Pending Injury efter deeth. investigation 1 Yes 2 No 2 Accident 6 Could not be determined within 24 hours efter decrease. To the Funeral Director completaly filled in by the 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

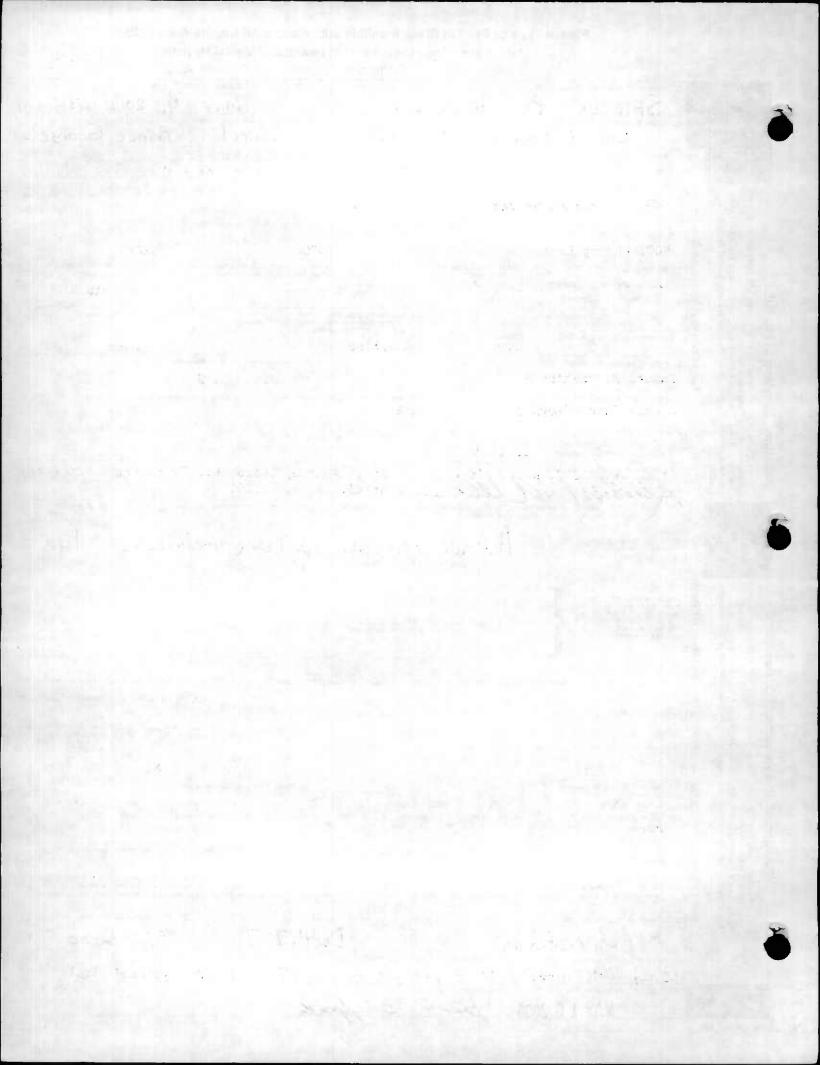
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical (Check only one) and manner stated. To the 29d. Date signed (Month, Dey, Year) 29b. Signature and little of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AVENUE LAUREL

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State Registrar 31. Date filed (Month, Day, Yeer)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month **Physician** LORRAINE 4b. City, Town, or Location of Death 620 Am 4c County of Deeth /Medical 4a Facility Nama (If not Institution, give street end number) Examiner Bellmiler 14 Hrs. Pay row 5. Social Security Number JOHNS 7. Aga (In yrs. last birthday) NA tf Undar 1 Yeer Months Deys 8. Data of Birth (Month, Day, Year) Birthpleca (Stete or Foraign Country) **Funeral** 212-26-0998 10M SEF Min. Hours Director Usual Residence of Decedent the Menylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ehow. item 27 le marked other than "naturel", or hams 23a or 28a-f eho other treumatic event, the Madical Exampler must be nottling at 1 PKYes 2 No Director BALTIMORE MC 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 3550 212 E USA Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedant Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status hours after 1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: 1 ☐ Nevar Married 2 ☐ Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 K Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other than Elementery/Secondary (0-12) Coilege (1-4or 5+) ATT. Md 12 VAULT NAT. 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fathar's Nema (First, Middle, Last) Be Peges 1 and 2 should be nent of Health end Mentel HAYDEN HOWARD 2 MARIE RAUGHBACK 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) permit. Peges 1 and 2 Department of Health e Important: If Item 27 le eny Injury or other tree Balto Md. HALL 21206 SHELDONAUE MICHAEL 4204 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 □ Cramation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 00 NATIONAL 21. Signeture of Fungeral Si 22. Name and Address of Facility T-UNIERAL IFER Nd21234 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failurg. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel disaasa or condition resulting in death) Examiner Due to (or es e consequence of) Eden sician end bunal-transit monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician es the bunal 68760 ance Physician/Medical Due to (or as e consequence of) Box ancer USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were autopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en autopsy performed? Completed peen has 1 🗆 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical examiner?
11 Yes 2 □ No
27. Manner of Death Be 26. Plece of Deeth (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 28e. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Neturel 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. 29a. Certifier completely (Check only one)

State Registrar

29b. Signeture end title of certifier

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Pfint)

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32. Registrer's Signature

29c. License number

29d. Date signed (Month, Dev. Year)

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 11:45 pm Month Calvin Cornelius Ingram, Sr. MAY 2000 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth DOCTOR'S COMMONITY HOSPITAL If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Months Deys Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 577-46-9609 1 M 2 F 66 April 16, 1934 Rockingham, Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 4209 Crittenden Street, #B U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Meritet Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Driver Private 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Calvin Ingram Cornelia LeGrand 19e. Informent's Name/Reletionship (Type, Print) Debra S. McMillan / Daughter 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition Chesapeantematory, Inc. 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Beltsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 5/16/00 Signature of Funeral Service Licenses 22. Name end Address of Fecility Latney's Funeral Home, Inc. 3831 Georgia Ave., NW, Wash., DC 20011 CC0348 Per11. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth tmmediate Cause (Final disease or condition resulting in death) Sepsis Syndrume Due to (or es a consequenca of): Metastate cancer of wrethra Due to (or es e consequence ol) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last Due to (or es a consequence of): 23b. Did tobacco use coptributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Deep venous thrombosis of left leg 24b. Were eutopsy findings evalleble prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 I Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menney of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

inding physicien end use as the burial-transit Box 68760 The law requires that the death certificate be P.O. Records, of Vital To the Hospital or Attending Physician: Division s after death.

Physician/Medical Examine à Completed Be Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

show

ms 23a or 28a-f short must be notified at

Funeral Director

Be Completed by

with the Maryland

altimore, Maryland

Pages 1 and 2 should be fill ment of Heelth and Mentel H tent: If item 27 is marked out

Physician /Medical

Examiner

Registrar **DHMH 16 Rev 6/95**

within 24 hours a

completely

State

29a, Certifier

(Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year) MAY 1 6 2000

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and menner stated. 29c. License number 034550

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

M.A. 4850 Forbes Blud Lunham, md. 20706 Hajjar, Jc. George

32. Registrer's Signeture

MAY I COME , Seems to opening

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED FIEM #20b PER FH G783 5/19/00 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Year **Physician** 6:55 AM EST Jones 05 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Maryland Medical Center Baltimore University of NA If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months 12 M 20 F 50 218-54-2236 Director MD 09-29-49 Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at yes 2□No Funeral Director MD NA Baltimore 28a-f 10e Street and Number 10f Zin Code 10g. Citizen of What Country? or Nems 23s or 1714 N. Castle Street 21213 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, Whita, atc. filed within 72 hours after 1 Never Married 2 ☐ Married Yes 2 No f Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify Completed by 3 Widowed 4 Divorced Black Year or Dates "natural" 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) GED Collega (1-4or 5+) NA Shaffer & Strominger Auto Mechanic 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumeme) Pages 1 and 2 should be of Health and Mentel If item 27 is marked of Arthur Jones, LeeVernia Bowden 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 2121319a. Informant's Name/Relationship (Type, Print) 3457 Mayfield Avenue Baltimore, Maryland Joyce Williams 20b. Place of Disposition (Name of VOSHELL MFM. Date cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriai 2 Cramation Sacred Heart Cemetery 05-18-2000 Dundalk, MD 3 DA Department of Important: If eny injury or 4 Donation 5 Othar (5) 22. Name and Address of Facility Baltimore, Maryland 21202 Signature of Funeral Service WM.C.March FH 1101 E. North Avenue Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pulmonary 8 hours Hemorrhage Examiner Due to (or as a sortsequenca of): Examiner Dagulopathy LIKROWN The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last bunisi-tran Due to (or as a consequence of and P.O. Box 68760, Physician/Medical the Dua to (or as a consequance of): use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown AIDS Division of Vital Records, Š 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed End Stage Renal Disease peen After this certificate has 1 Yes 25 No 1 ☐ Yes Physicien: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA spital or Attending Physical ster death.

nerel Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of injury 28c. fnjury et Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Hospital of To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) 00 Mawan

Registrar **DHMH 16 Rev 6/95**

State

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Dunaway

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31. Dete filed (Month, Dey, Year)

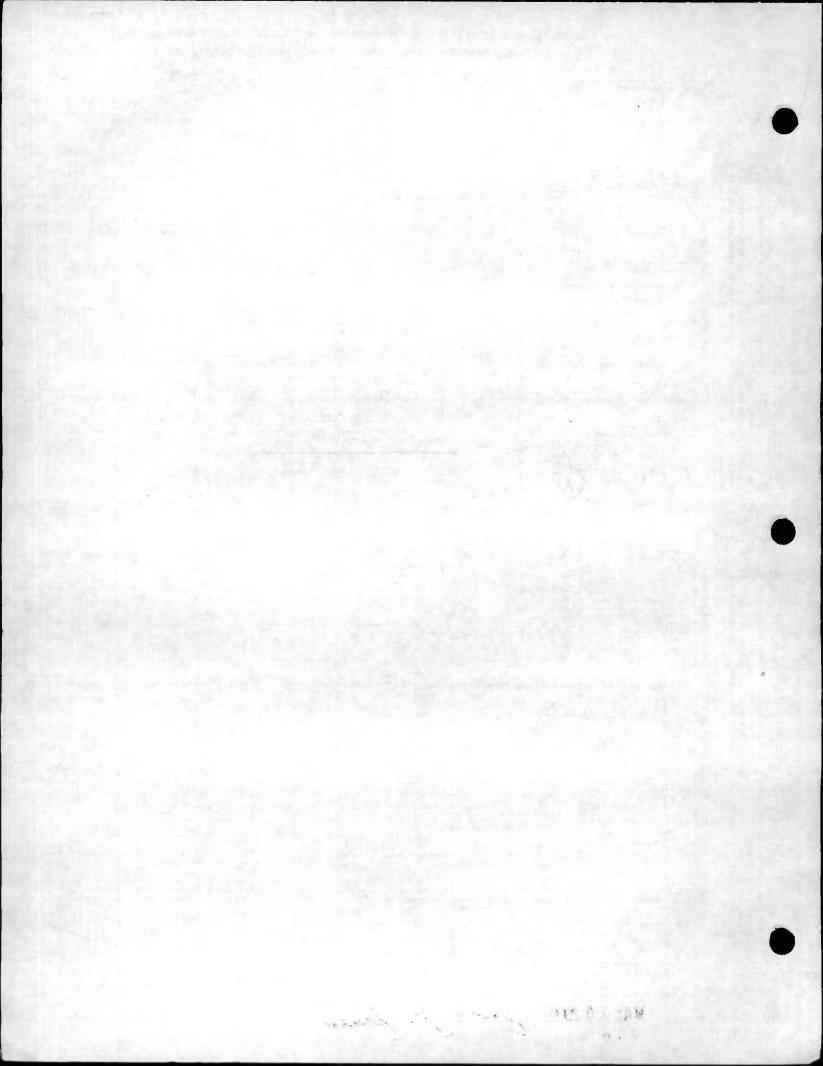
30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print)

32. Registrar's Signature

S. Greene St.

Baltimore,

ORIGINAL



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The law requires that the death certificate be executed

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after death

within 24 hours a To the Funeral I completely filled Hospital

To the

Box 68760.

P.O. |

Records.

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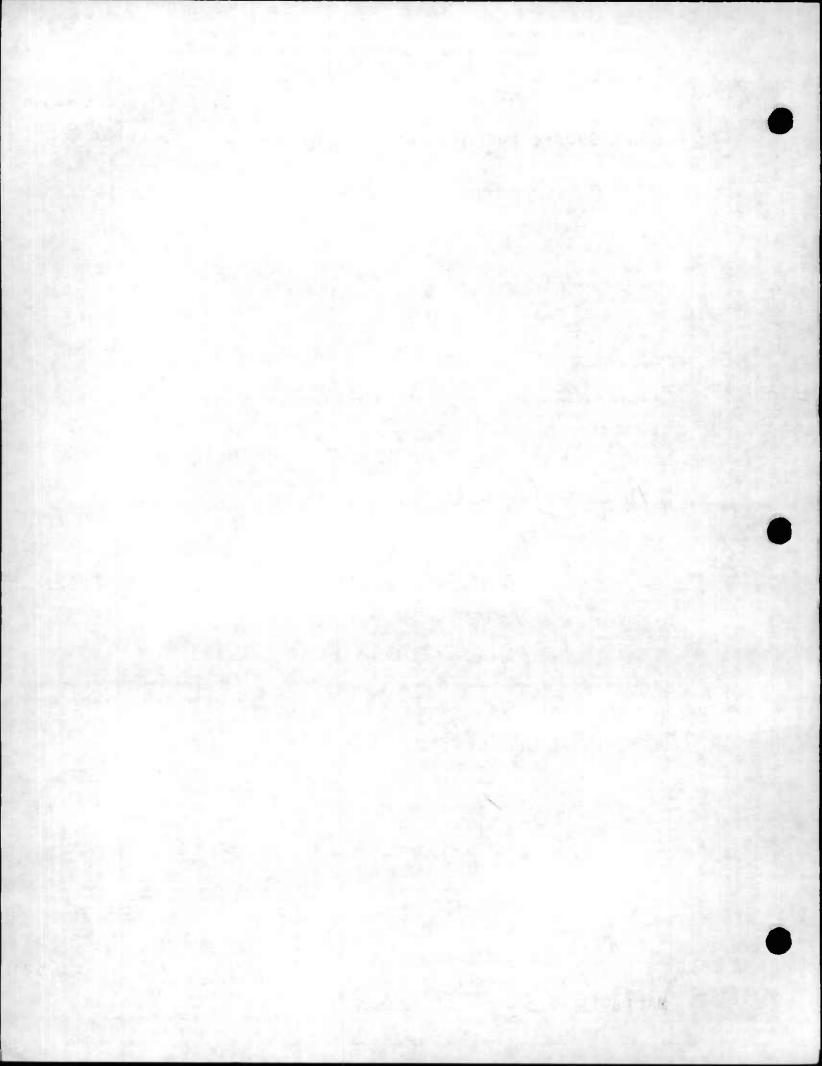
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Department of Important: If any Injury or

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 5 6 2 8

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 13 2000 5:45 pm **Physician** LILLIAN JACKSON May /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Hospital Center RoseDale If Under If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) April 11 1923 9. Birthplaca (Stata or Foraign Country) Virginia **Funeral** Months Deys 10 M 80F Hours 218-22-3939 Director Usuel Rasidence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. tnsida City Limits Md Baltimore Middle River 1 ☐ Yas 2 € No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 11 Walkway Court 21220 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11 Medial Status 1 ☐ Yas 2 Ø No If Yes, Giva 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 6th own home 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be unknown Emma Keys 2 19a. Interment's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) Donald Jackson/son 11 Walkway Court Baltimore Md. 21220 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Removal trom Stata 4 ☐ Donation 5 ☐ Othar (Specify) Holly Hill Cemetery 5/17/2000 Baltimore **MAryland** 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or commentions that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart teilura. List are cause on each lina. Approximata Intarvel Batwaen Onsat and Death **Physician** /Medical Immediate Cause (Finel hythmias disaasa or condition rasulting in death) Examiner Dua to (or as a consaquanca of) Physician/Medical Examiner FAILURE Sequantially list conditions, if any, laading to immadiate cause. Entar Underlying Cause (Diseasa or Injury that initiated avents rasulting in death) Lest Due to (or as a consequence ot) Hemin Dua to (or as a consequance ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause ot death? 24a. Wes en autopsy performed? Completed 1 Yas 2 No 1 □ Yas 2 □ No 25. Was casa referred to medical axaminer? Be 26. Placa of Deeth (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant edical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Data of Injury (Month, Dey Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicide 28a. Place of tnjury - At homa, term, street, factory, offica building, atc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and manner stated. 29a. Certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian MD 30. Name end eddrass of person who complated cause of death (Itam 23a) (Type, Print) SQUARE PRIVE BALLIMORE, MARYLIMO 21237 9000 FRANKLin WASEEM 31. Data tiled (Month, Day, Year) MAY 1 6 2000 32. Ragistrar's Signatura

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May Margaret I. Jewell 13 2000 10:55 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Millennium at South River Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) July 6, 1913 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 578-40-9816 86 Vre Panama Director Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Menylan Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 N No Director Anne Arundel Edgewater 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Riverside Road 21037 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22. No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 t. Marital Status 14. Raca - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Saitimore, Maryland 21215-0020 1 ☐ Yes **②**XNo Specify: Specify White þ 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be George William Strong Isabelle Scott Henderson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Riverside Road, Edgewater, MD 21037 Keith L. Jewell (Son) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 05/15 20c. Location - City or Town, State 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 2000 Baltimore, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hardesty Funeral Home, P.A. ala 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) 10 MINUTES CARDIAC ARRHYTHMIA Examiner Due to (or as a consequence of) MORE THAN Examiner CARDIO VASCULAR DISEASE HTHEROSCLEROTIC YEAR physicien and s the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 88 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MACULAR DEGENERATION Records, þ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ROTATOR CUFF TEAR. 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata RECURRENT C. DIFF. COLITIS Division of Vital 25. Was case referred to medical exeminer? or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tittle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

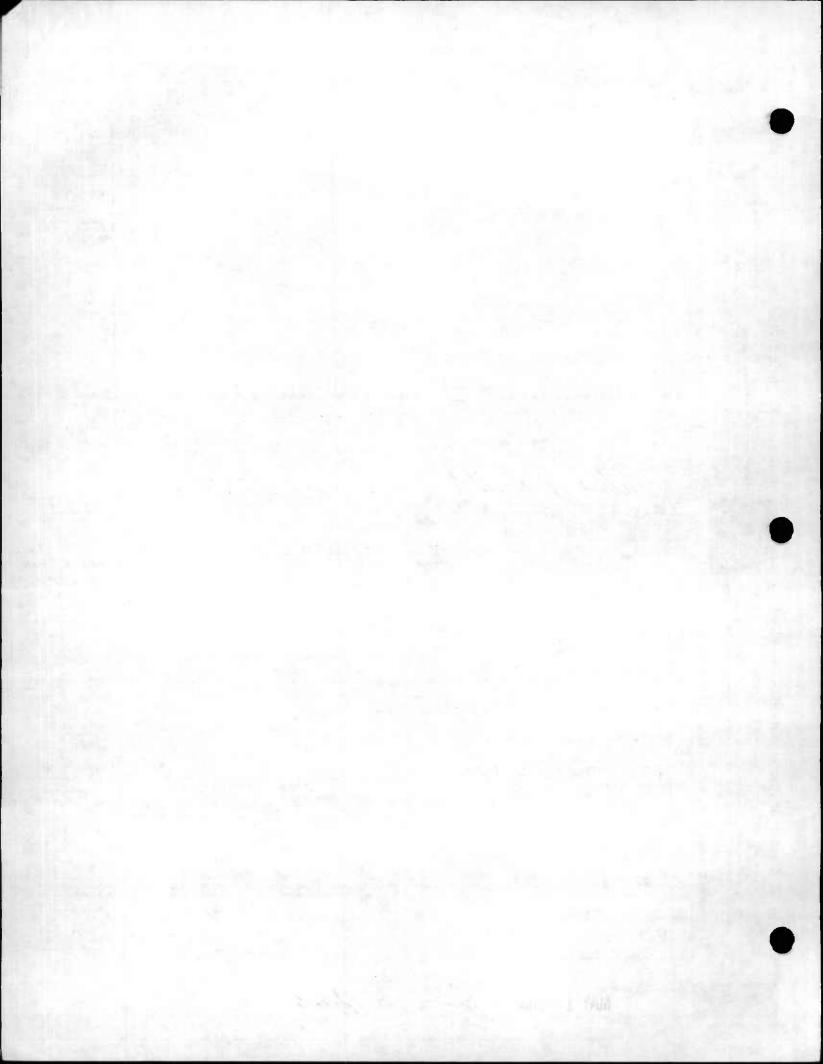
eyan - c. Sinana

D. 50653 105-15-2000

GYAN-C. SURANA 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Deale Chunchton Road. Deale. mp.

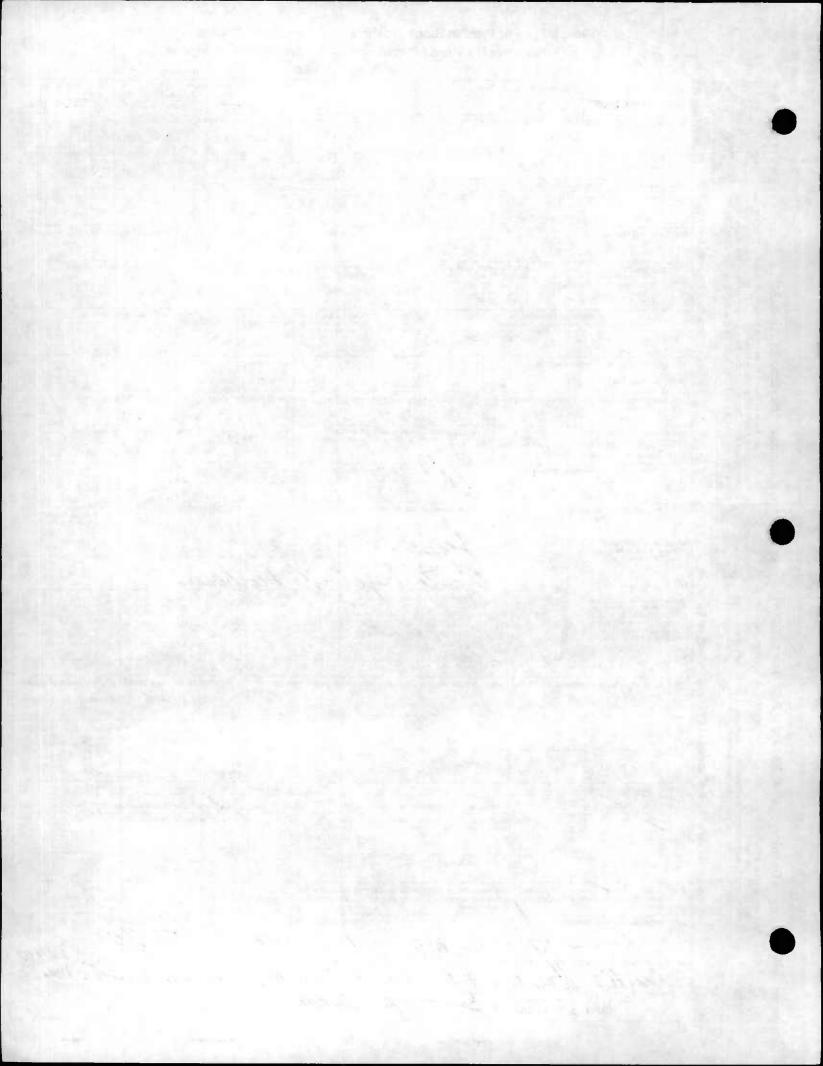
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 6 2000

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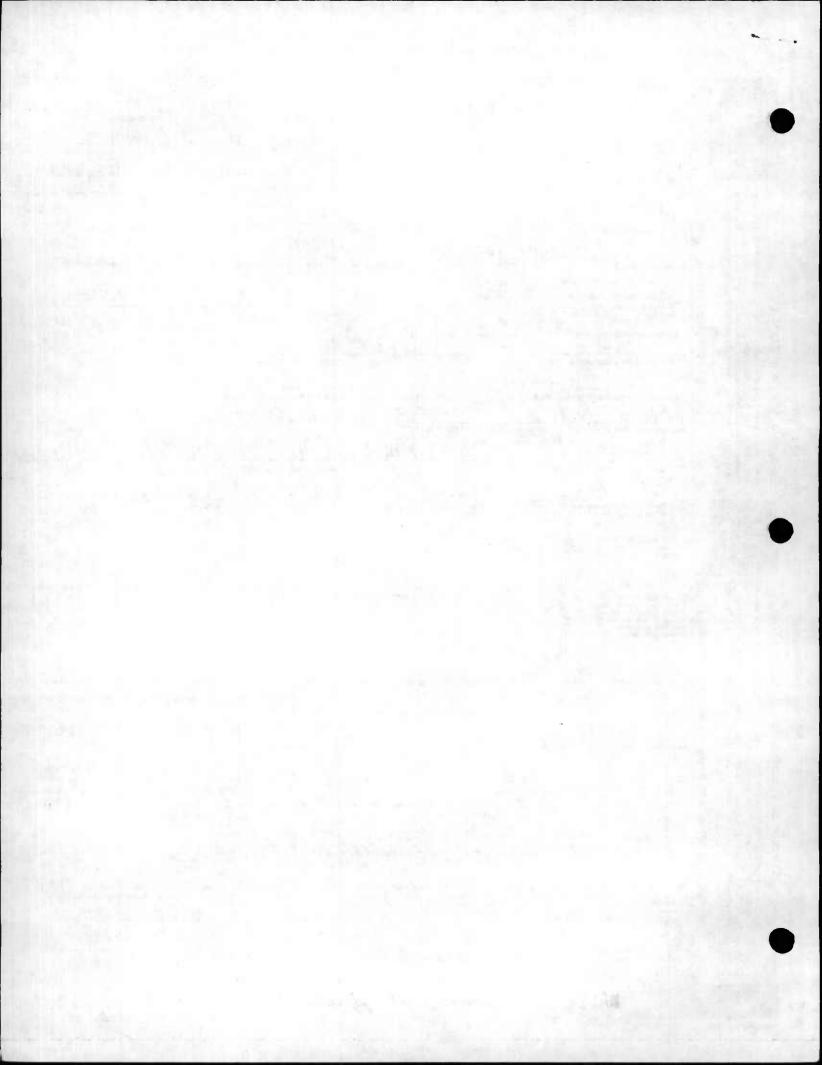
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by	1 3 0	Never Merried 2 Widowed 4 □ D		Armed Force 1 Yes 2 If Yes, Give Yeer or Date	es? Ligno		as Decedent of H Yes, specify Cuba □ Yes 2[X]No		rto Rican, etc.)	Specia	ock, White, by: W	etc. nite
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Medical Examiner	Sequent of eny, l. cause. Cause that init resulting	art1. Enter the discock, or heert failure to Ceuse (Final or condition g in deeth) tially list condition adding to immedia Enter Underlying Disease or injury eted events g in death) Last		licetions thet cause on eed	Sep	a a conseque	ence of): yelvence of):	g, such es cardle				Approximate Interval Batween Onset end Death
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Daath Month Dav Year **Physician** Koerber 2000 55 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Maris SAICU
7. Age (In yrs. last birthday) If Undar 24 Hrs. Hours Min. (M Birthplaca (Stata or Foraign Country) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) **Funeral** Days 1 M 2 X F 25 Yrs. 220 Director Maryland filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Herns 23a or 28=1 show ent, the Medical Espential and be notified in 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f shored est 1 ☐ Yes 2 Nio Director 10e. Street and Numb 10f. Zip Code 10g. Citizan of What Country? Funarai 12. Was Decedent Ever in U.S. Inned Forces?
1 ☐ Yes 2 (VNo If Yes, Giva Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 1 □ Never Married 2 □ Married Specity: White 1□ Yes 2♥ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Casualty Md. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mentel Hygler Important: if Item 27 is marked other th any fujury or other treumatic event, the page. om Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) 8 Harve 2000 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City oc Town, Stata, Zip Coda) Baltimore BROTHU Md 21234 20a. Method of Disposition 20b. Place of Disposition (Name comatary, crematory or othe Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fameral Service Ligens 22. Nama and Addrass of Facility vaks 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) ABDOMINAL CANCER Examiner Due to (or as a consequence of): Examiner The lew requires that the deeth certificate be executed sician and burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Neva Koerber signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 N Unknown Records, Š Ba Complated 24b. Wara autopsy lindings available prior to pege 2 should 24a. Was an autopsy completion of causa of death? this certificata 1 ☐ Yas 2 X No 1 ☐ Yas 2 ☐ No Division of Vitai or Attending Physician: director 25. Was case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 NOther (Specify) HOSPICE Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 XNatural 5 Pending ne Hospital or Attending n 24 hours after deeth. he Funerel Director: Aft 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 ☐ Could not be detarmined To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completaly filled in by the 3 Suicide 28l. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 1143721 00 1-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Data filed (Month Pay, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Deeth 3. Time of Death Month **Physician** Audrey 9:40PM MAY 2000 10, /Medical 4e Fecility Neme (If not-institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner MEDICAL CENTER GREATER BALTIMORE BALTIMORE TOWSON If Under 1 Year Months Deys 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth Month, Day, 9. Birthplece (State or Foreign Country) **Funeral** Hours 1 M 2 S.F 217-38-5503 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No LHMORE Funeral Director Imonium 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxicen, Puerto Rican, etc.) Race - American Indien, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried Specify: White Maryland 21215-0020 1 Yes 2 No Specify: Completed by Yaar or Datas: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 19e. Informent's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) IIMONIUM, Baltimore, 20b. Placa of Disposition (Name of cemetery, cramatory or other place 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Segrice Licensed 23a. Part I. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximeta Intervel Between Onset and Deeth **Physician** Immediata Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner 0 sician and burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in daath) Last Due to (or es e consequança of) Box 68760, the Dua to (or as a consequence of): use es ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Dld tobacco use/contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings eveileble prior to completion of causa of death? 24a. Was en eutopsy performad? edical Certification: To Be Completed 1 ☐ Yes 2 No 1 Yas 2 No the funeral director, 25. Was cesa refarred to medice! 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Hospital: 1 Yes 2 No 1 1 Inpatiant 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Menner of Deeth 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred After t To the Hospital or Attending 5 Pending Investigation s after deeth. 1 Yes 2 No 2 Accidant 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, deta end place, and due to the cause(s) end menner stated. 29e. Certifier completely 29b. Signeture and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) D52197 M.D 05-11-00

Registrar

State

EKHA

Kemp

AME:

31. Dete filed (Month, Day, Year) MAY 1 6 2000 32. Registrer's Signeture

aBMC

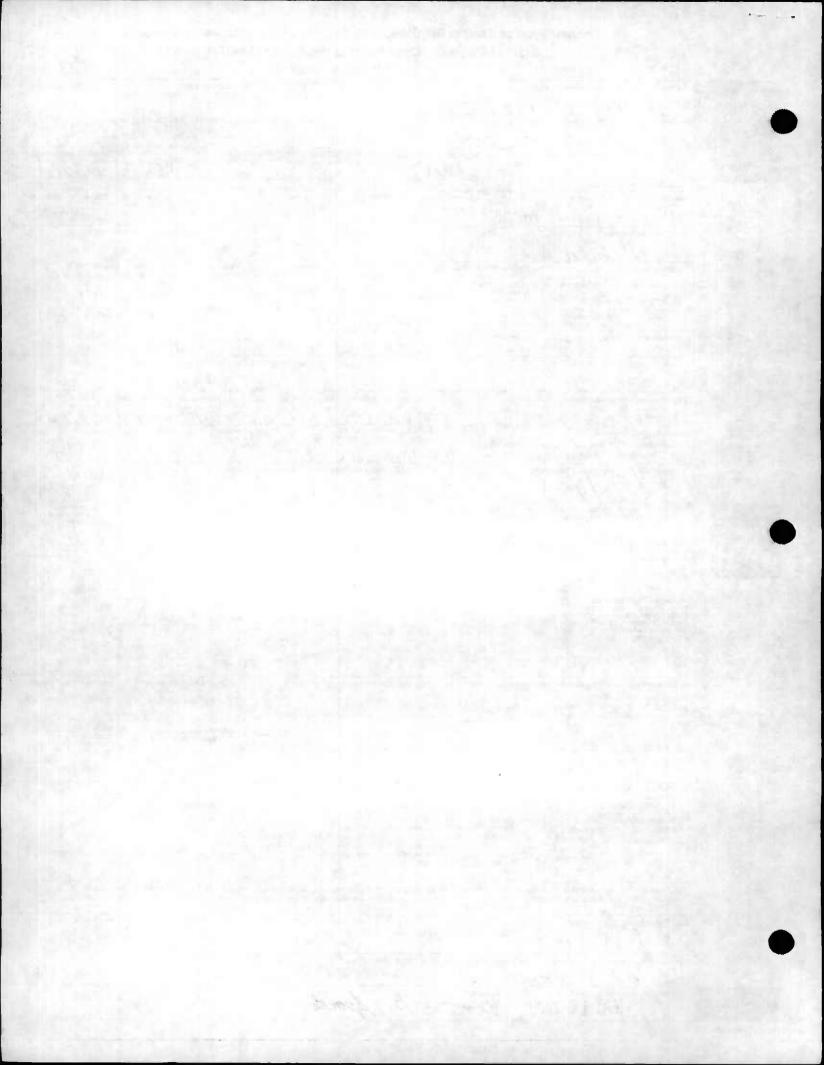
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

MOTAGI

to be soon

6701 N. CHARLES ST.

BALTIMORE MD 21204



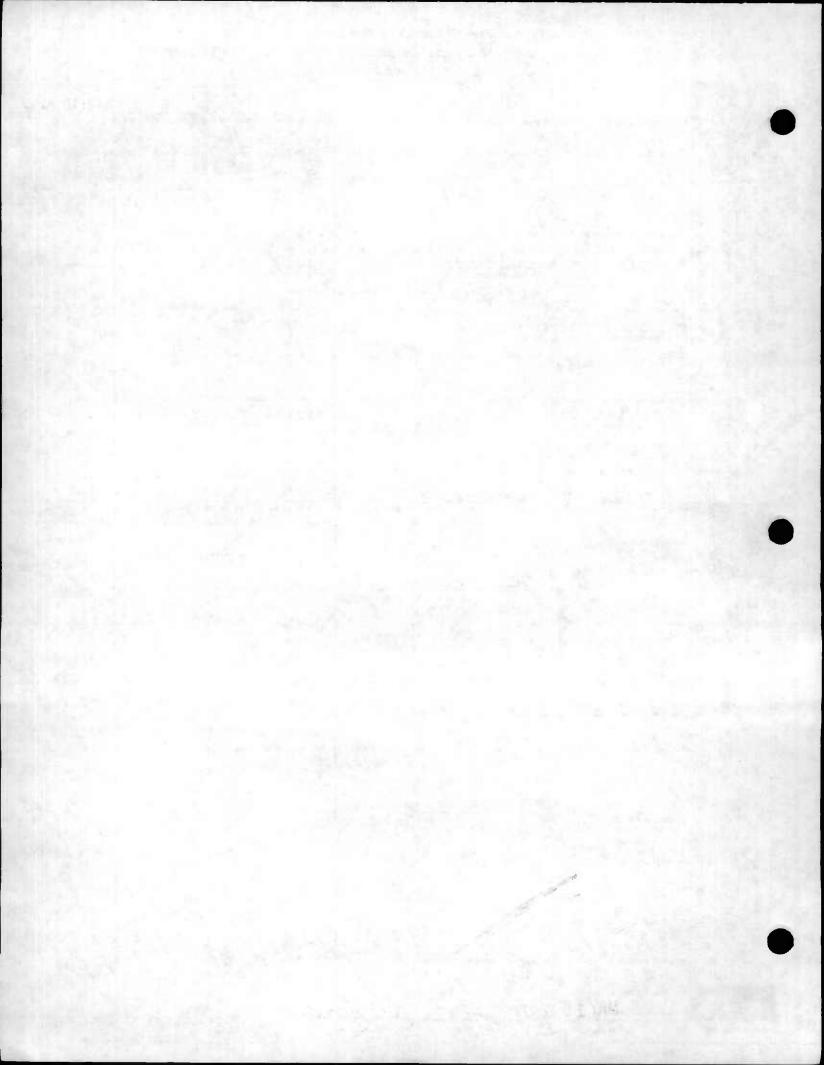
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State of Maryland / Department of Health and Mental Hygiene 15633

ician				Certifica	ate of	Death		F	leg. No.		
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niner	4a Facility Nama (If not institution	n, <i>giv</i> a street and numbe	er)			4b. City, To	wn, or Locat	ion of Death	4c. Co	unty of Daath	
	7910 Quaker 1	Neck Road					ertow	_		Kent	
	5. Social Security Number 213 14 5424	6. Sex 7. 1 ☐ M 2 💢 F	Aga (in yrs. ias 79	Yrs. If United Month	der 1 Yaar ns Days	If Undar 2 Hours	Min.	Data of Birth (Month, Dey 11y 29	Year) 192		pplaca (Stata or Foraign intry) iryland
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	Patricia Condi	ton / Dau		3637 Cha		ROAU					yland 2104
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	21. Signature of Funaral Sarvice	Licensee Bramer	nusk	1.		ass of Facility	GC			1 Home , Md.	
	234. Part 1. Enter the disease of shock, or heart failure. List Immediate Causa (Final disease or condition resulting in deeth)			STIVE is a consequence of						e	Approximate Interval Batween Onset and Death IO YEAR
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DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Yee **Physician** 10 Peter Joseph Keefer, Jr. may 20m /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) AUG 16, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 110 M 2□ F Yrs. Director 097-10-8750 New York Usual Residence of Decedent 10a, State 10b County 10c. City. Town or Location 10d. Inside City Limits than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 N No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 53 Northwood Drive 21093 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Rece - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiane. other than Elementery/Secondary (0-12) College (1-4or 5+) Assembly Line Container Company . Peges 1 and 2 should be filed w ment of Heelth end Mental Hyglar lant: If Itam 27 Ia marked other ti jury or other traumatic avent, to 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peter Joseph Keefer, Sr. Louise Burns 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and Depertment of Heelth Important: If Itam 27 I any Injury or other tri once. Peter Joseph Keefer. III/Son 53 Northwood Drive Timonium, MD 21093 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/12/00 Baltimore, MD 21. Signeture of Funeral Service License 22. Name and Address of Facility
Cremation Society of MD, Inc. Cremation Society of MD.

Fdward A. regorchik

299 Frederick Road Balti

23a. Pertl. Enter the disease, or complications thel caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. regorch 299 Frederick Road Baltimore, MD 21228 Approximete Intervel Between Onset and Death **Physician** week Immediate Cause (Finel disease or condition resulting in death) /Medical namonia Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): physician is the burial that initieted events resulting in death) Last Due to (or es e consequence of) US0 85 cata has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No Completed by 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No funaral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 215 No 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural Ne Hospital or Attending in 24 hours after death.

The Funeral Director: After pletely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Division of Vitai

The law requires that the death certificata be axecuted

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After this

To the Hosp within 24 hor To the Fune completely fi

or Attending Physician:

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filed within 72 hours after

Saitimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certif

Was 1945499 31. Dale filed (Month, Day, Year) 32. Registrar's Signature MAY 1

30. Name and address of person who completed cause of death (Ilem 23a) (Type. Print)

DO.

FACE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Light Control of the basis of examiner: On the basis of examinerion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

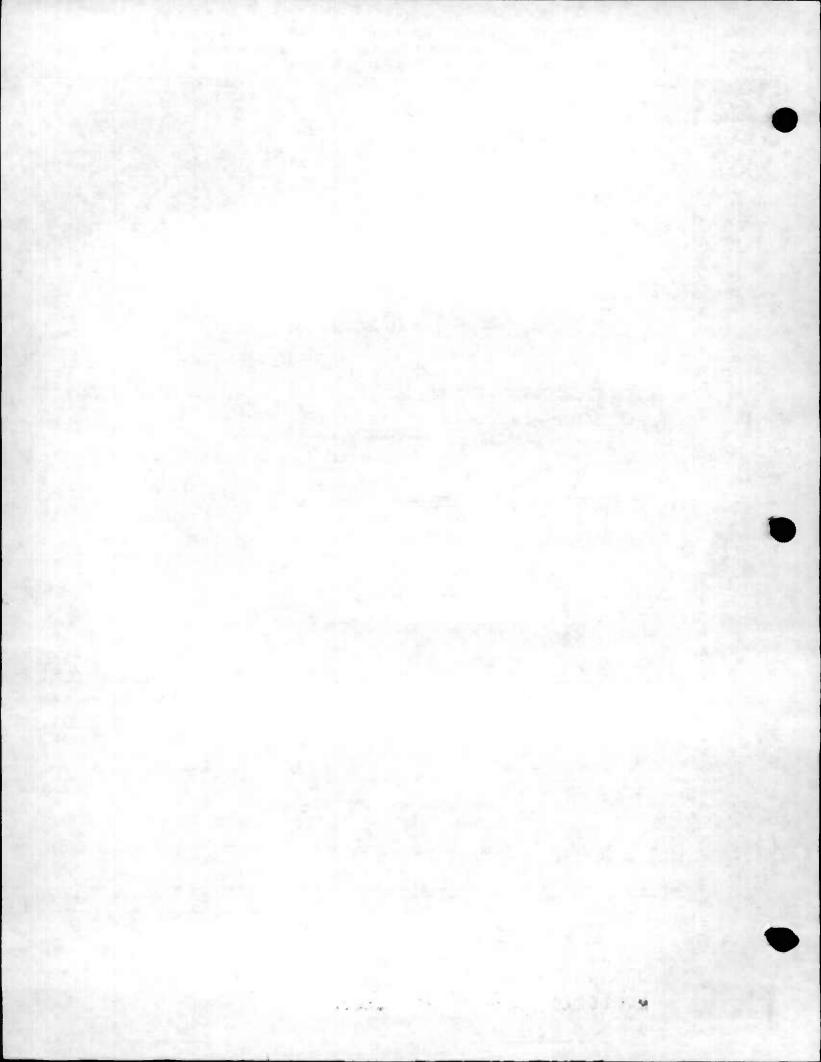
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Date signed (Month, Dey, Year)

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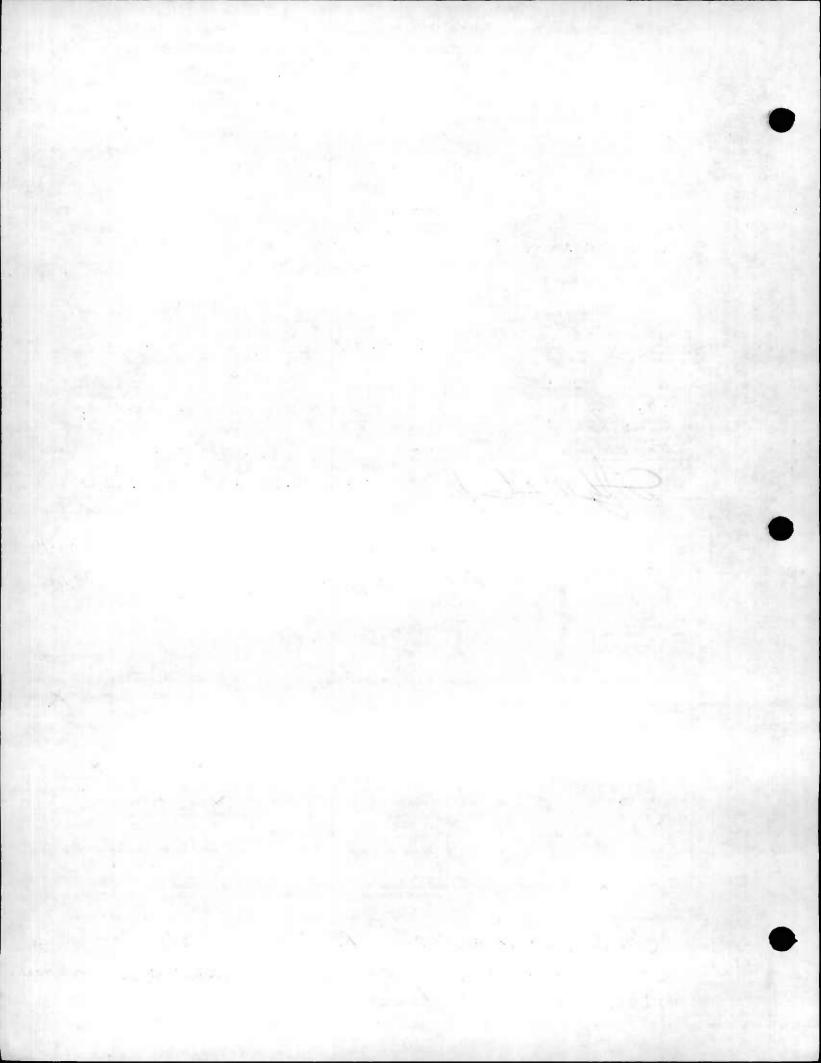


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 15636

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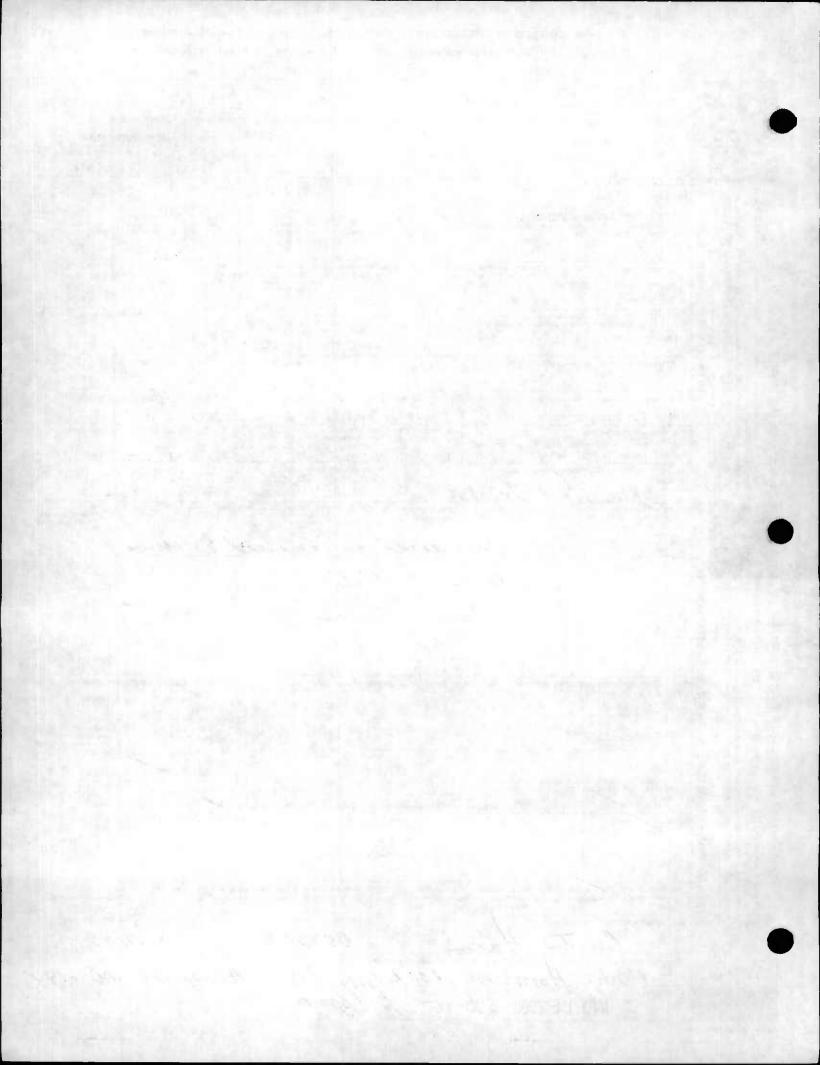
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 5 6 3 9 State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certain	0	~	29c. L		1	9d. Date signad	(Month, Dey, Year)		
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30. Name and address of person who			(1)		- 0		2		
2	2 Accident Suicide Homicide (Check only one) 2 Act III. Other eignificant conditions of the condition	Sequentially list conditions, fany, leading to immediate ause. Enter Underlying cause (Disease or Injury hat initiated avants esulting In death) Last Seart II. Other eignificant conditions contributing to deeth but d	Sequentially list conditions, fany, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated avants esulting In death) Last Sert II. Other eignificant conditions contributing to death but not resulting to death	Sequentially list conditions, fany, leading to immediate ause. Enter Underlying cause (Disease or Injury hat initiated avants esulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d	Due to (or as a consequence of): ause. Enter Underlying ause (Disease or injury hat initiated avants esulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C.		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND#8 PER K.B. 5-16-2000 State of Maryland / Department of Health and Mental Hygiene AMEND #1 PER MD. 5-16-2000 JAB G783 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death FEBRUARY POY **Physician** 2000 4:50 p.m LINBERGER /Medical 4c. County of Death 4a Facility Neme Iff not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 24 Hrs Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M Hours Unknow Yrs Director Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10d. Inside City Limits City, Town or Location must be notified at 1 19 1es 2 □ No **Funeral Director** 288-4 rimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or d d items! 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 11 Marital Status filed within 72 hours effer 1 Yes 2 H If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0020 6 2310 Specify à 3 ☐ Widowed 4 ☐ Divorced ac Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) /A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be finent of Health end Mental I hert: If Item 27 is marked of perger Unknow 19a. Informent's Name/Relationship (Type, Print) City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number Department of Health elimportant: if Item 27 is any injury or other trau Himore, Md. 2/224 mother ineberger Saltimore, 20b. Place of Disposition (Neme of Date 20c. Location ; City or Town, State 20a. Method of Disposition metery, cremetory or other pleci 1 ☐ Burial 2 ☐ Cremention 4 Donation 5 Pother (Specify) 5059 22. Name and Address of Fecility 21. Signature of Funeret Service HH-600 N. Wolfe St. Approximate Intervat Between Onset and Deeth 23a. Pert1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) PREMATURITY Two DAYS Examiner Due to (or es a consequence of) Examiner PULMONARY HEMORRHAGE IWELVE HOURS The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) TWENE HOURS Box 68760. HEMORIRHAGE FNTRAVENTRICULAR Physician/Medical the Due to (or as a consequence of) USB 85 RESTIRATORY FAILURE WELVE HOURS P.O. Pert if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown METABOUC ACIDOSIS of Vital Records, g 24a. Was en autopsy performed? 24b. Were autopsy tindings available prior to edical Certification: To Be Completed completion of cause of deeth? certificate has No No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 8 Other (Specify) s after death.

Il Director: After this ed in by the funeral di 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end manner steted. completely 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) RES-000 FEBRUARY 17, 2000 MD 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) JoHNS HOPKINS BALTIMORE MARHUND 21287 600 NORTH WOLFE STREET, HATTANGEDI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 6 2000

ORIGINAL

1. Decedent's Neme /First. Middle, Last) 2. Date of Death Month **Physician** MAY EONARDO /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BALTI MORE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) JOSEPH 5. Social Security Number 2:40A RICHIE HOSPICE If Under 1 Yeer | Months Days 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 3 (6 Yrs. **Funeral** Days 215-86-4179 JUNE 10, 1963 NEW Director Uauat Residence of Decedent r 28a-f ahow 10a. Stete 10b. County 10c. City, Town or Location BALTIMORE Director MARYLAND 3 MAY 2000 10e. Street and Number 10g. Citizen of What Country? tem 27 is marked other than "natural", or items 23s or other traumatic event, the Medical Examiner must be a STREET 2523 MC HENRY 12 2 Funeral 12. Was Decedent Ever in U,S. Armed Forcea? 1 ☐ Yes 2 No If Yes, Give Year or Detes: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 Yes 20 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mentel Hyglene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) 12 +HGRADE NEVER WORKED Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If Ikan 27 is marked otth any Injury or other treumatic event Pates. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be IONY MARTIN MARVIN JONES DOROTHY 19e. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) KEELS (COUSIN) BROADWAY STACIA BALTIMORE MD. 21205 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from State CEMETERY 5-17-00 LANSDOWNE, M.D. 4 ☐ Donetion 5 ☐ Other (Specify) 10N 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 23. Name end Address of Fecility 24. Name end Address of Fecility 25. Name end Address of Fecility 26. Name end Address of Fecility 27. FUNERAL Home 28. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, 28. Approximate 29. Name end Address of Fecility 29. Name end Address of Fecility 20. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 21. Approximate 29. Name end Address of Fecility 20. Approximate 20. App **Physician** Immundet Syndrome Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner attending physician and if for use as the burial-trensit Due to (or es e consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thury that initiated events resulting in death) Last Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24e. Wea an eutopsy 1 Yes 2 No 25. Wea case referred to medicat 26. Place of Deeth (Check only one)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Nomul 1 Yes 2 No 27. Manner of Death 28b. Time of

28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Defeural 1 Yes 2 No 2 Accident

6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted. 29a. Certifier

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death

VORK

1 Yes 2 No

10d. Inside City Limits

2000 2:40 AM

Birthplece (State or Foreign Country)

NIA

Year

45A.

14. Race - American Indian, Bleck, White, etc.

BLACK

MARTIN

Approximete Intervet Between Onset and Death

24b. Were eutopsy findings eveilable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) staller m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bauto 21287 St. 600

State Registrar

Box 68760.

P.O.

Records,

Division of Vital

Physician/Medical

Completed

e

10

Certification:

Medical

this certificate

Hospital or Ath.

* Hours after death.

*real Director: Ah.

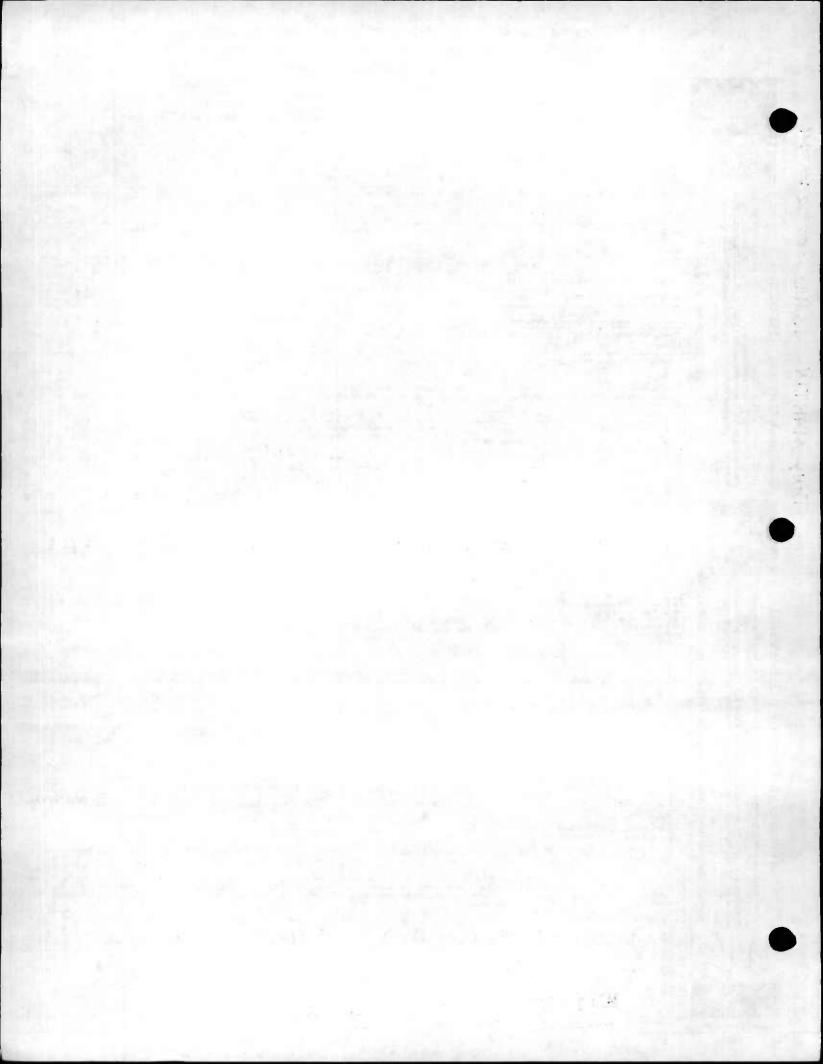
*ed in by the fur-

To the Hospi within 24 hou To the Funer completely fill

Attending

31. Date filed (Month, Day, Year) MAY 16

32. Registrer's Signature Segina



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month

1. Decedent's Name (First, Middla, Last) **Physician** 05 SIMON HENRY MOHR 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9112 ENNINGS ROSSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 F Yrs 89 Director 218-18-5608 Feb. 27.1911 Maryland Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore County Directo 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? b 21237 9112 Lennings Lane IISA "natural", or flams 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes (2) No If Yas, Giva Wes Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Married > Merried 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0020 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A 7th grade Machinst Federal Government permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Importants if New 27 is manked other
any injury or other traumgite some 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theresa Hoffmeister Simon Henry Mohr 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 9112 Lennings Lane Baltimore, Md. 21237 Mrs. Etta C. Mohr (Wife) 20e. Method of Disposition

↑ Buriel 2 □ Cremetion 3 □ Removal from Stata 20b. Plece of Disposition (Neme of cemetary, crematory or other pleca) 20c. Location - City or Town, Steta Zion Cemetery 5-15-2000 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 23a Pert1. Enter the disease, or complications that eaused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** PNEUMONIA Immediate Cause (Final disease or condition resulting in deeth) /Medical PINE WEEK Examiner Examiner SUBDURAL HEMATOMA WITH
Due to (or es e consequence of): attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury PERMANENT NEUROLOGICAL IMPAIRMENT
Due to (or es a consequence of): Box 68760 Physician/Medical thet initieted events resulting in death) Last LEFT HE MIPARESIS P.O.

Pert ff. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part f.

CEREBROVASCULAR ACCIDENT

CHRONIC OBSTRUCTIVE PULHONARY DISEASE

24e. Wes en eutopsy performed?

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings eveilable prior to completion of cause of death?

6:16 PH

1 ☐ Yes 2 💢 No

1 ☐ Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was casa raferred to medical exeminer? 1 Yes 2 No 27. Mennar of Death

5 Pending investigation

28e. Dete of Injury (Month, Dey Year) 6 Could not be determined 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 ☐ Nursing Home 5 🛣 Residence 8 ☐ Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar

1 Naturel

2 Accident

4 D Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and mannar es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29c. License number

29b. Signature end title of certifier

D42986

29d. Date signed (Month, Day, Year) 2000

30. Name and address of person who completed cause of deeth (frem 23a) (Type, Print) DR. JOYCE E. KING, H.D.

FRANKLINSQUARE DR #205 BALTIMORE MD 21237

26. Placa of Death (Check only one)

State Registrar 31. Dete filed (Month, Dey, Year) MAY 1 6 2000 >

32. Registrer's Signeture

DHMH 16 Rev 6/95

Records,

Division of Vital

certificate

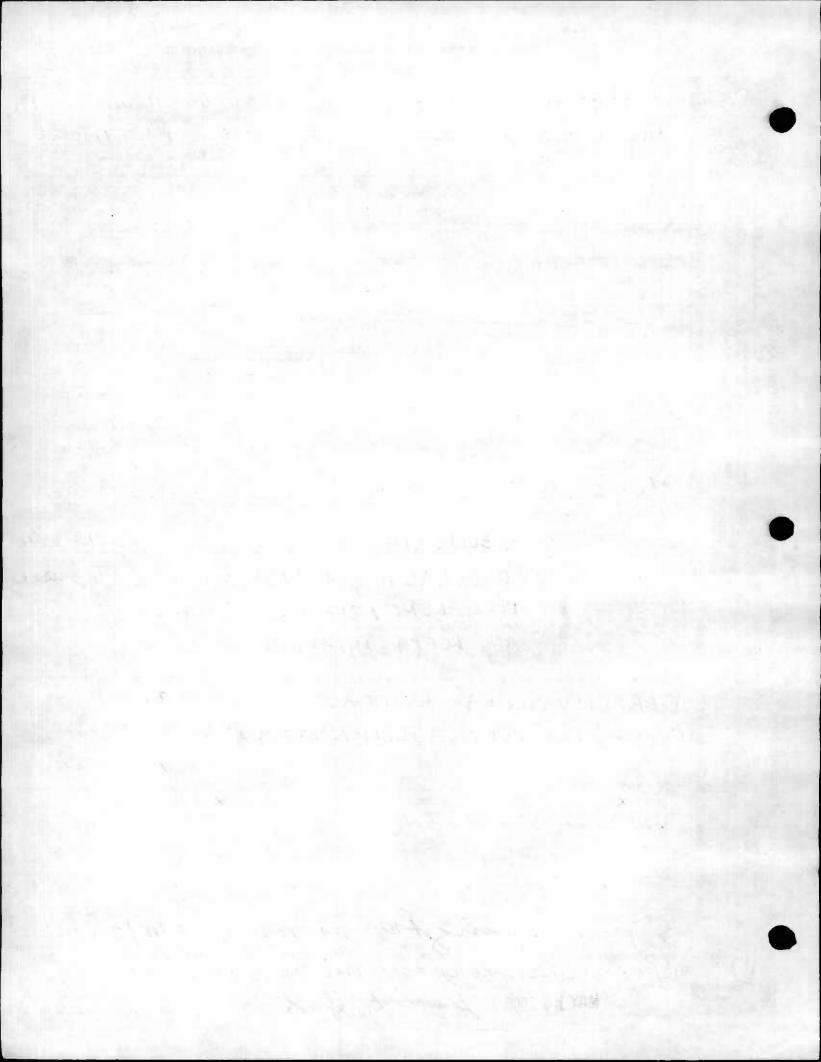
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To the Hospital or Attending Physician: within 24 hours after death.

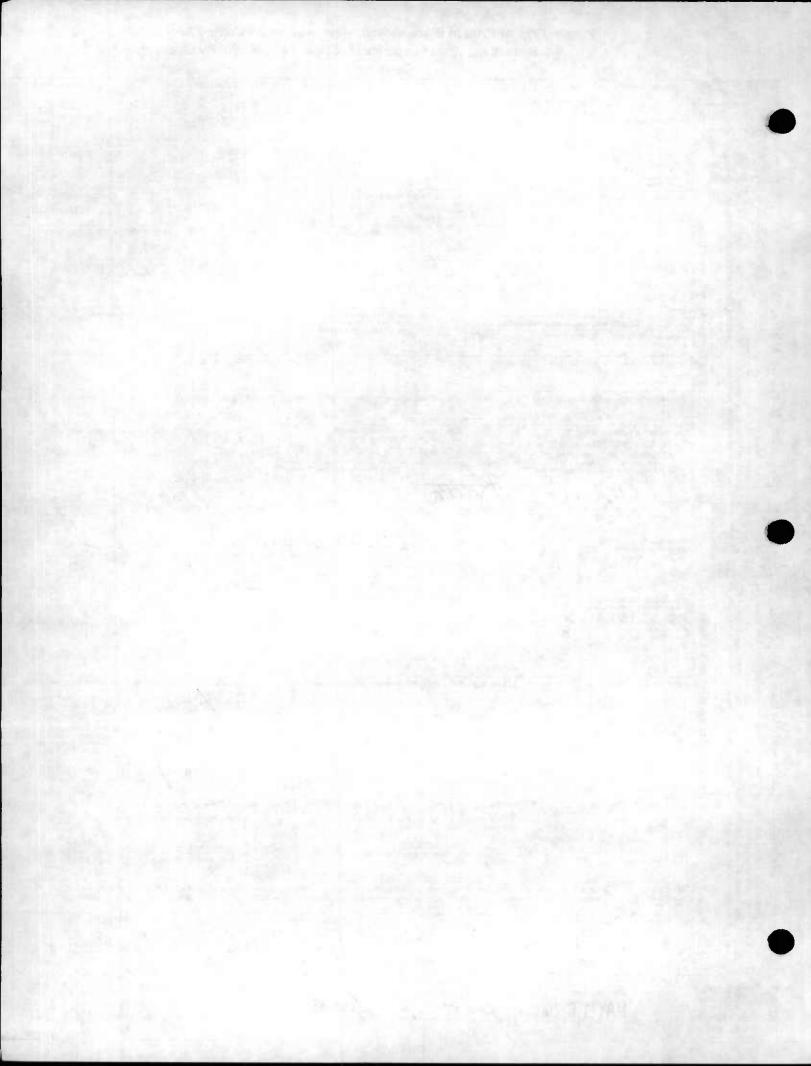
To the Funeral Director: After this certifica completely filled in by the funeral director; I



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15513

	Certificate of	of Death	Reg	3. No.	00.40	
	Decedent's Nama (First, Middle, Last)		2. Data of Death Month	Day Yaer	3. Tima of Deeth	
Physician /Medical	Eloise F. McKenney			14 2000	9:15 a.m.	
Examiner	4a Facility Nama (If not Institution, give street and number)	4b. City, Town, or L	ocation of Death	4c. County of Death		
	632 Londontown Road	Edgewate	r	Anne Arun	del	
Funeral Director	5. Social Security Number 6. Sax 7. Age (tn yrs. last birthday) 1 f Under 1 Ye Months De	8. Data of Birth (Month, Dey,) July 21		nplace (Stata or Foreign Intry) hington, DC		
2 2	Usual Rasidance of Decedent 10a. Steta 10b. County 10c. City, Town or Location				10d. Insida City Limits	
or death with the Maryler learne 23s or 28e-f show the mat be notified at uneral Director	MD Anne Arundel Edgewater		140	1 □ Yas ŽŒNo		
23a or 1 ust be n	10e. Street and Number 10f. Zip Coo	21037		untry?		
	11. Marital Status 1 □ Nevar Married 2 □ Married 1 □ Nevar Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedant Ever in U,S. Armed Forcas? 1 □ Yes 2 ☒ No If Yes, Give Yaar or Datas: 13. Was Decedant ff Yas, specify C	of Hispenic Origin? (Sp Cuban, Maxican, Puarto No Specify:	ecify Yes or No- Rican, atc.)	r No- 14. Race - American Indian, Black, White, atc. Specify: White		
Maryland 21215-0020 d.2 should be filled within 72 hours at the and Mericlal Hyglene. T is marked other than "natural", or trearmatic event, the Medical Exam To Be Completed by F	Elementary/Secondary (0-12) Collega (1-4or 5+)	cupation na during most of work tired)	ring	16b. Kind of Business/Industry		
and 2 the filled with Hygie od other avent, the Be Co	10 Homemaker 17. Fethar's Name (First, Middle, Last) Stephen Russell	100	e (First, Middle, Ma	Own Home	7 211	
To To	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Str		Thompson	City or Town State 7	in Code)	
CHME	Barbara A. Keane (Daughter) 8334 Mary Le	ee Lane, La	urel, MD	20723		
Baltimore, semit. Pages 1 a Separtiment of Her mportant: if them my injury or othe page.	20a. Method of Disposition 1X Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cematary, cramatory or other Lakemont Memorials)	place) (C	5/18	Dc. Location - City or T Davidsonvi		
Ball permit Depart Import any in		drass of Facility By Funeral Gely Avenue			401	
	23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of shock, or heart failure. List only one ceuse on each line.	* *	-		Approximeta Interval Batween	
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) a. Dua to (or as a consequence of):	A		· ·	Onset and Deeth	
Box 68760, seth certificate be executed attending physician ending properties as the bunletrensit clany Medical Examines	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
P.O. hat the d dot by the deteched	Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause	a givan in Part I.	23b. Did tobacco use contribute to the cause of Yes 2 No 3 Probably 4 L			
cords requires been sign should be			performed? available		Nara autopsy findings available prior to completion of cause of deeth?	
The lew ate has page 2			1 □ Yas	20 No 1	☐Yes 2☐ No	
r Vital relean: The s certificate director, pag	25. Was case raferred to medical examiner?	26. Place of Dea	th (Check only ona,)		
- 5 9 5	1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		oma 5 Aesidan	nca 8 Othar (Spec	:ify)	
VISION O Attending Ph or death. ector: After th by the funeral	2 Accident Investigation M	njuryat Work? 1 □ Yas 2 □ No	28d. Dascribe hov	v injury occurred		
Division (but or Attending P ts after death. at Director: After teled in by the funer: Certification:	3 ☐ Suicida 4 ☐ Homlolda 6 ☐ Could not be determined 28e. Plece of Injury - At homa, farm, street, factory, off building, atc. (Specify)	ice	28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)			
Hospi 14 hour Funer tely fill	29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the contro	a tima, data and placa, ny opinion, daath occur	end due to the ceu red at the time, dat	use(s) end mennar as te end plece, and due	stated. to the cause(s)	
To the within 2 To the comple	30. Nama and address of person who completed causa of death (Item 23e) (Type, Print)	ansa number	3 29	d. Date signed (Mon)th	Day, Year)	
State	H.D. Gold Stein and 2056 31. Date filed (Month, Day, Year) 32. Registrar's Signetura	10 dely	Hue	- Ann	abot? we	
Registrar	MAY 1 6 2000 Server & April	Ms /				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2000 **Physician** William Michael Martellucci Month 12, May 14:25 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Hospice Towson MD Baltimore H Under 1 Year | H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 036-20-5240 Birthplece (State or Foreign Country)
 RI 7. Age (In yrs. last birthday) **Funeral** 10XM 2□ F 83 Yes 1916 Director Nov. 2, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford Belair 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Chaucer Lane 21014 United States Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? T[n] Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. pemit. Pagas 1 and 2 should be filed within 72 hours after a Department of Health and Mentel Hygiene. Important: if then 27 is marked other than "natural", or then any injury or other treumatic event, the Medical Experience page. Black, White, etc. Unk. Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☑ Married 1 Yes 200 Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plating 0 Electric Plater 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Francesco Martellucci Angela Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Fay Martellucci / Wife 204 Chaucer Lane, Belair Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☑ Removel from Stete St. Ann's Cemetery May 18, 2000 4 □ Donation 5 □ Other (Specify) Cranston, RI 22 Name and Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 21. Signature of Euneral Service Licensee Victor P. Doda, Jr. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical recurrent Aspiration weeks Dueumna Examiner Due to (or as e consequence of): Physician/Medical Examiner weeks acute stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 70 we 24b. Were eutopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) + 03 pt (e 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

or Attending Physician: The law requires that the dasth certificate be executed P.O. Box 68760, Records, Division of Vital To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

signed by the attending physician end if he deteched for use as the burist-transit

this certificate

After

director.

funeral

29a. Certifier (Check only one)

29b. Signature and talk of ception

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Baitimore, Maryland

State Registrar

DHMH 16 Rsv 6/95

31. Date filed (Month, Day, Year) MAY 1 5 2000

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30. Name and address of person who completed cause of death (Her

ley

6701 6BMC 32. Registrar's Signature

A. Charles St. Balto. Md 2120/

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and menner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29c. License number

125205

29d. Date signed (Month, Day, Year)

ORIGINAL

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23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dey Month Yeer **Physician** DOROTHY NELSON 131 MAY 6.25 AM 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTI MORE 600 D SAMARITAN N/A HOSPITAL If Under 1 Year It Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. JAN 2, 1919 9. Bigholice (Stete or Foreign MARYLAND 5. Social Security Number 7. Age (In yrs. lest birthdey) 1 □ M 2√2 F 81 Yrs 215-24-4142 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No N/A MD BALTIMORE CITY Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 348 S. ELRINO STREET 21224 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indien 11. Meritel Status Black, White, etc. 1 □ Never Merried 2 □ Merried 1 Yes ZXNo 1 ☐ Yes 2 XNo Specify: Specify: WHITE ₩idowed 4 Divorced þ Completed 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be WILLIAM FISHER ELLA KELLNER 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 7523 NORTH POINT ROAD BALTIMORE, MARYLAND 21219 MELVIN B. PIKER - FRIEND 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donetion 5 ☐ Other (Specify) OAK LAWN CEMETERY 5/18/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or reart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Finei diseese or condition resulting in deeth) HYPOXIC ISCHEMIC ENCEPHALOPATHY 6 days Due to (or as e consequence of) Physician/Medical Examiner ASYSTOLY Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence ot): 15CHEMIC DISEASE HEART Due to (or es e consequence of): resulting in deeth) Lest Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DISSEMINATED INTRAVASCULAR COAGULATION à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Tyes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpetient 3 DOA 27. Menner of Death 28c. tnjury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident

anding physicien and use es the buriel-transit death certificate be executed P.O. Box 68760. foru Records, s certificate hes b director, page 2 s^o Division of Vital director,

Funeral

Director

show

7 is marked other than "natural", or frems 23s or 28s-f shor traumatic event, the Medical Examiner must be notified at

Hygiene.

permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked other any Injury or other traumatic event.

Physician

/Medical

Examiner

the Menyland

filed within 72 hours efter death with

3altimore, Maryland 21215-0020

Hospital or Attending Physician: 24 hours efter death. Funers! Director: After this certifica filled in by 24 hours To the Hosp within 24 hor To the Fune completely fi

Registrar

Medicai

6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

P-12560

29d. Dete signed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) ANU GABA, RESIDENT, DEPT. OF MEDICINE, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD

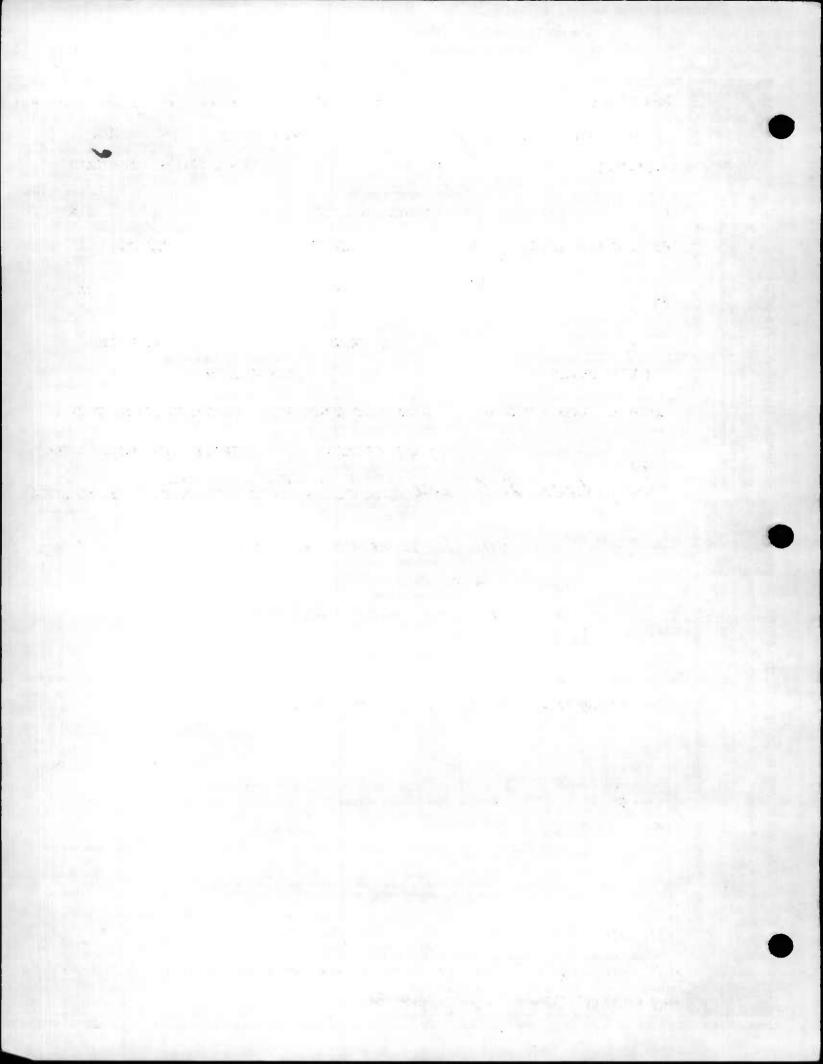
31. Dete filed (Month, Day, Yeer) MAY 1 6 2000

29b. Signature end title of certifier

Coopin goll

32. Registrer's Signeture

MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:00/10 30 2000 April Bertha M. Polesne /Medical 4a Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Perry Hall Baltimore 4334 Chapel Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdev) 8. Date of Birth (Month, Dey, Year) **Funeral** Davs Months Hours 10M 20F Director 91 1/21/1909 Perry Hall, MD 220-46-5497 Usual Residence of Deceden death with the Maryland 10a. State 10d. Inside City Limits 10b. Counts 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Perry Hall Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò LISA 21128 Herna 23a 4334 Chapel Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status filed within 72 hours aftar 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) pemit. Pagas 1 and 2 should be filed with Department of Health and Mental Hygien important: If them 27 is marked other try any injury or other trauments. Home Housewife N/A 12 years 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Ida Emma Rauschenbach John Everett Newman 0 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 401 East Jefferson St. Suite 201 Rockville, Md 20850 Gilbert E. Tietz (guardian of property) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removel trom State 5/4/2000 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6.1 E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087 6.0 Lassahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Not Know EMONTH Examiner Due to (or as a consequence of) Examiner physician and s tha burial-transit certificata be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of) as

Physician/Medical þ

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To the Hospital or within 24 hours aft To the Funeral Di complataly filled in

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Division of Vital

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

leted cause of death (Item 23a) (Type, Print)

28c. Injury at Work? 1 Yes 2 No

26. Plece of Deeth (Check only one)

BALTIMU Md 2123

28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated.

24a. Was an autopsy performed?

1 Yes 2 No

28d. Describe how injury occurred

29b. Signature and title of certitier

30. Name and address of person who cor

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 GNatural

2 Accident

3 Suicide

29a Certifier

4 Homicide

29c. License number 1)18 738

16000

29d. Date signed (Month, Dev. Year) 2000

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 2 No

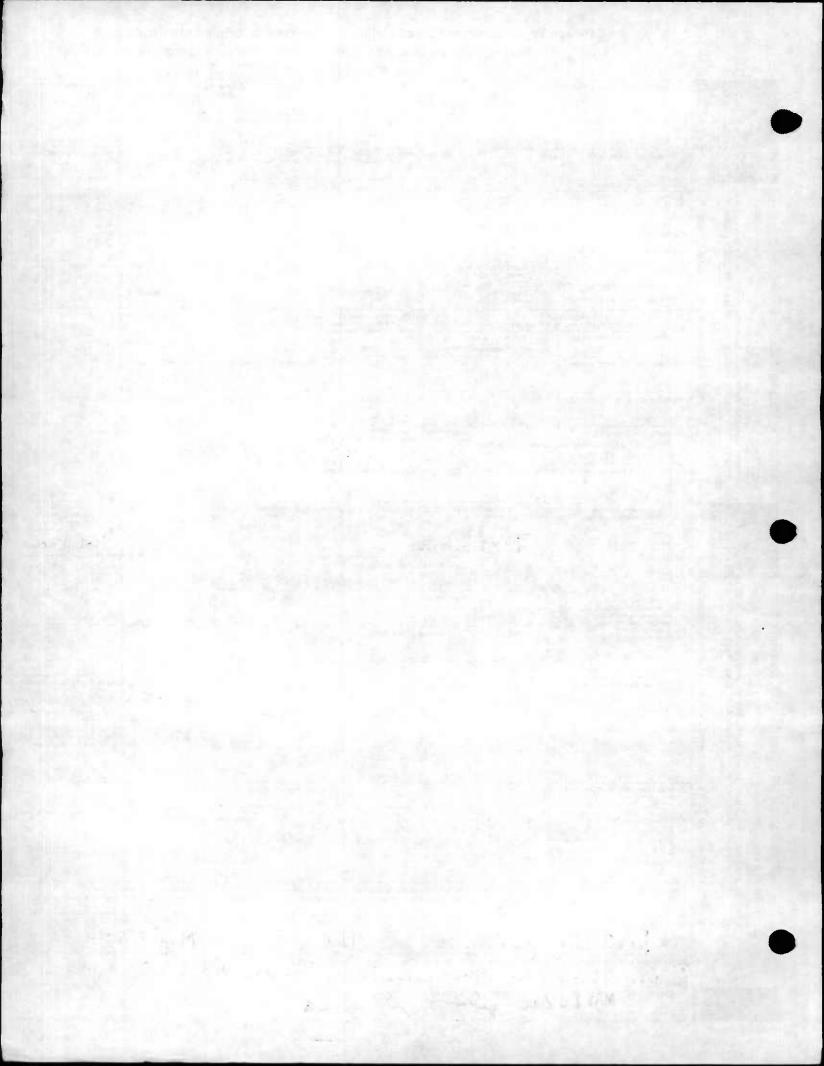
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9660 Belson 31. Date tiled /Montl 32. Regisfrar's Signature

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Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Day 09 Month MA 4 PALASIK MADELINE 8: 00 AM VERONICA 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HARBOR HOSPITAL CENTER If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Aga (In yrs. last birthday) Months Days Hours 1 M 2 F 93 214 54 1795 Jan. 25, 1907 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 - 5th Avenue 21225 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowad 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6th 18. Mother's Name (First, Middle, Meiden Surnama) 17. Father's Name (First, Middla, Last) Magdaline Saj Joseph Glodek 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnforment's Name/Relationship (Type, Print) 303 - 5th Avenue Baltimore, Maryland 21225 Dorothy Palasik / Daughter 20b. Place of Disposition (Name of cemetery, crematory or othar place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 5/11/00 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramerous phications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease shock, or heert faiture. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRO VASCULAR ACCIDENT DAYS disaese or condition resulting in death) Dua to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings evailable prior to 24a. Wes en autopsy performed? CONGESTIVE HEART FAILURE completion of cause of death? 1 Yes 2 No 1 Yes 2 No PNEUMONIA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

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Physician

/Medical

Examiner

Director

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Certification:

3 Suicida

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title of certifier

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If flem 27 is merked other than "natural", or tea any Injury or other traumatic event

Physician /Medical

Examiner

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altimore, Maryland 21215-0020

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edical State

Registrar

DHMH 16 Rev 6/95

FARAM MARINA MD 31. Date filed (Month Pay Year) 2000

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S HANDVER STREET 3001 32. Reģistrar's Signature

MO, PGY-1 INTERN

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. Licensa number

P 13471

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MAY

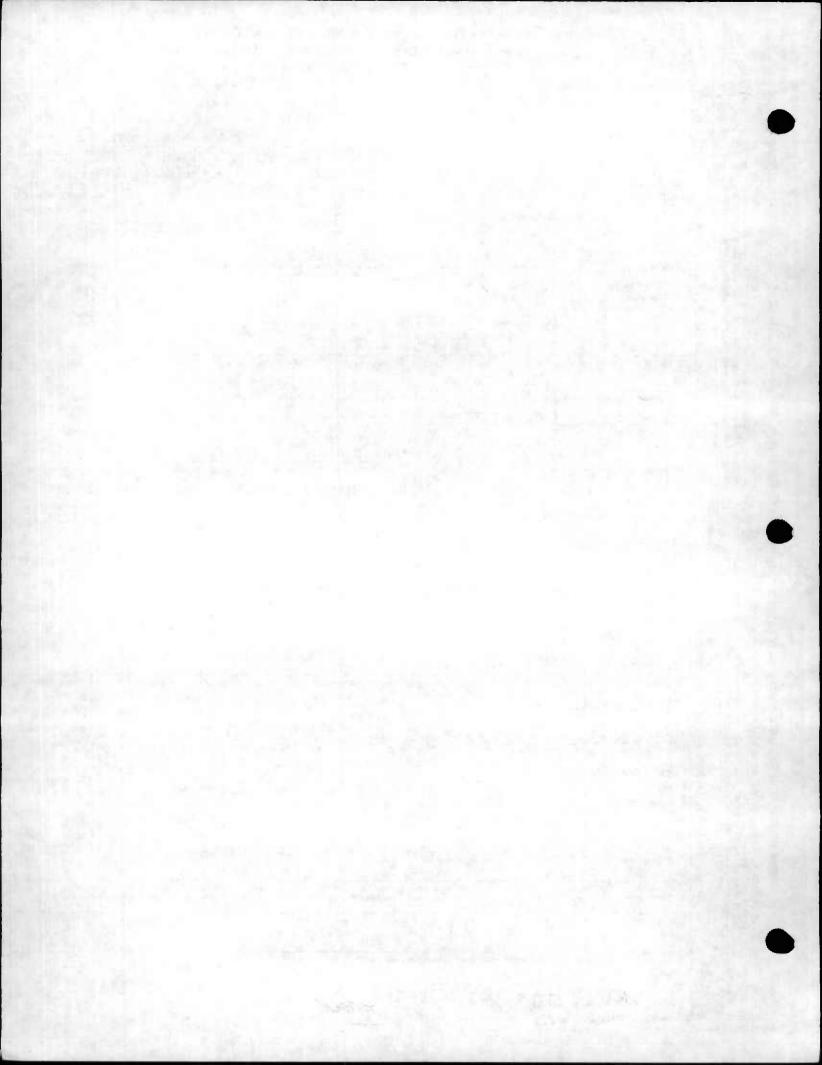
BALTIMORE, MD

29d. Date signed (Month, Day, Year)

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2000

21225



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month GERTRUDE **PEARMAN** MAY 2000 12:55 PM 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 24, 1916 If Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys Months Hours 1 □ M 21X F Yrs 219 16 4766 84 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2K No Anne Arundel Maryland Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8467 Miramar Road 21122 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Cyran John Wenerski 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Haskell Drive Granddaughter Arnold, Maryland 21012 Lorena Swepston / 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Glen Haven Memorial Park 5/12/00 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Home P.A. 23a. Part1. Enter the disease, or amplifications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. Et a propose cause on each line. 4001 Ritchie Highway Baltimore, Md. 21225 Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) LYMPHOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy 20 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♥ No

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Director

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permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Haalth and Mantal Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with Injury or other treumstic event, the Medical Example must be not ited. 2008.

3altimore, Maryland 21215-0020

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Hospital 24 hours

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Division of Vital Records, P.O. Box 68760,

Physician/Medical by Completed 96 2 Certification:

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27. Menner of Deeth

1 Natural
2 Accident

3 ☐ Suicide

29a. Ceftifier

4 T Homicide

State Registrar 29h. Significand and dille of certifier and address

of/person who completed cause of death (Item 23a) (Type, Print)

28a. Dete of Injury (Month, Day Year)

29c. License number D-50274

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 5-10-2000

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

A.J.COSTE, LT. MC. USN 31. Date fited (Month, Day, Year) 32. Registrar's Signature

MAY 1 6 2000

28c. Injury at Work?

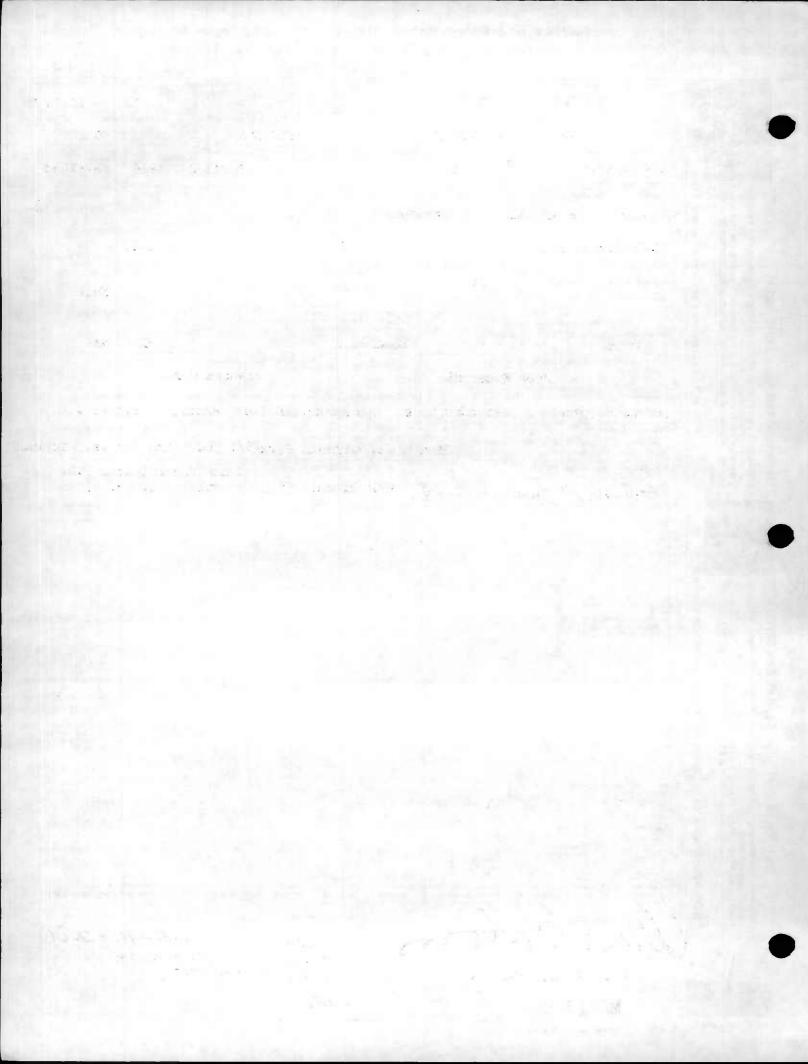
1 ☐ Yes 2 ☐ No

DHMH 16 Rev 6/95

RTTET -

5 Pending investigation

6 Could not be determined

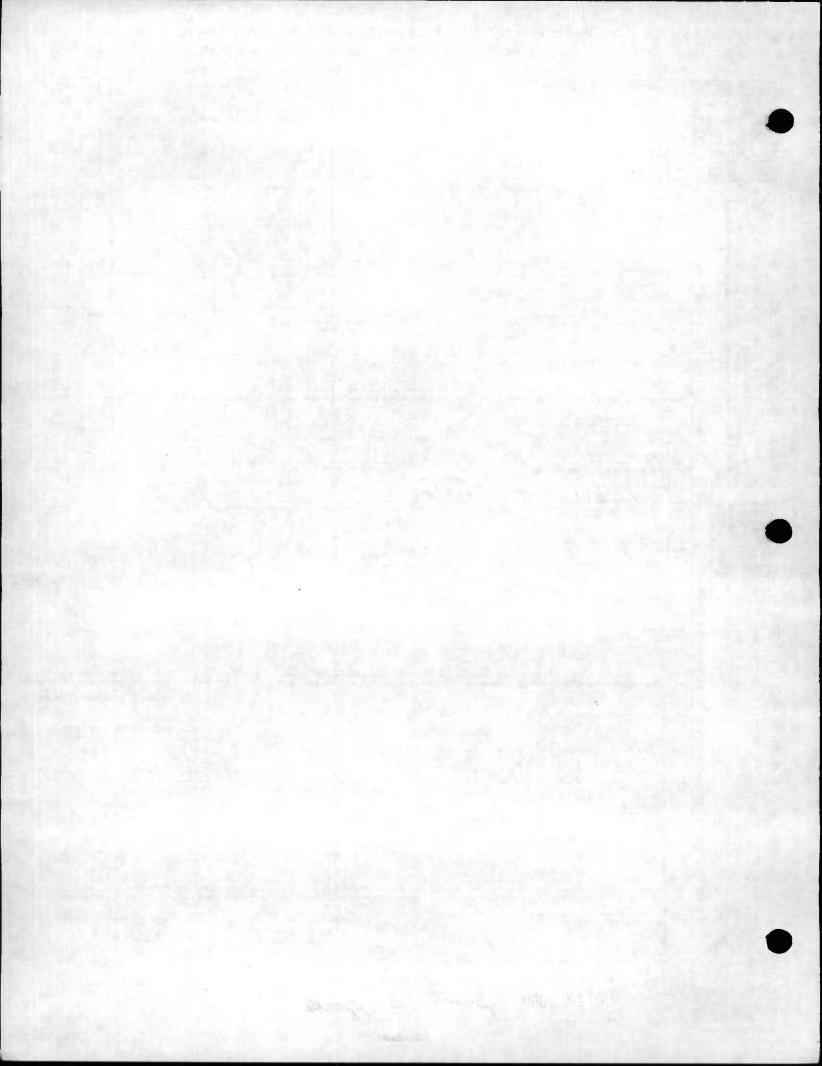


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Day Month **Physician** John Robert Phibbons 4:00 pm May 14 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4317 Solomons Island Road Anne Arundel Harwood ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours XXM 2 F Yrs. 218-36-3612 Director 89 May 7, 1911 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Harwood 10f. Zip Coda 10g, Citizen of What Country? 10e. Street and Number 4317 Solomons Island Road 20776 USA death Funeral permit. Peges 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if flam 27 is marked other than any Injury or other traumed. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give 1 ☐ Never Married 2 X Married 1□ Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cattle Farmer Agriculture 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Earley Phibbons Ethel Elizabeth Wayson 2 19b. Mailing Addrass (Straat and Numbar or Rural Route Numbar, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 4317 Solomons Island Road, Harwood, MD 20776 Doris C. Phibbons (Wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a Method of Disposition 05/17 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 2000 4 ☐ Donation 5 ☐ Other (Specify) Lothian, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Fecility Hardesty Funeral Home, P.A. ulla 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaan Onset and Death Physician /Medical Immediate Cause (Final diseese or condition rasulting in death) Examiner Due to for as a consequence of): Examiner Hive Nesse Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): 2 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by I 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Homa 512 Rasidance 6 □ Other (Specify) 10 1 Yes 2 No thin. 28a. Date of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Athar 1 DNaturai Division 5 Pending investigation 1 Yes 2 No death 2 Accidant Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida after 6 24 hours at Funeral Dietely filled 1 Certifying Physician: To the best of my knowledga, daeth occurred at tha time, date and place, and dua to the cause(s) and manner as statad.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the To the To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 ME MO PRHAME 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** William Robinson :04pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) **Examiner** Centel Himore If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 213-10-949Le Usual Residence of Decedent 1 MM 2□ F Yrs Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) insurance agence Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be fill thant of Health and Mental Hitant: If from 27 is marked oth Be KOKINSON onanna Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) IMONIUM 20b. Plece of Disposition (Name of cemetery, cremetory or other p 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If its any injury or of May 16 1 Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Furtheral Service Licenses vans 2800 BROL the mode of dying, such es cardiec or respiratory arrest, Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 3 min Examiner 6 che Physician/Medical Examiner mona Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760 Muluy Due to (or as a consequence of): on aun Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificata 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medicat 26. Place of Death (Check only one) 1□Yes 2/1No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) My CL Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury el Work? 5 Pending investigation **↑**□Naturat deeth. 1 □ Yes 2 □ No 2 Accident To the Hospital or Attand within 24 hours after death To the Funeral Director: A completely filled in by the f the 6 ☐ Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) A 29b. Signature 29c. License number 29d. Date signed (Month, Dey, Year) 12/00 9 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ILWILL AMS 6BAC 31. Date filed (Month, Day, Year) NAY 1 6 2000 State Registrar

ORIGINAL

9HMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month MARY JANE ROTH 12:30pm 15 2000 MAY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18 Crafton Road Essex Baltimore If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Aga (fn yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) Days Months Hours 215-14-9687 Nov 30 1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yas 2 ☐ No **Baltimore** Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Crafton Road 21221 USA 12. Was Dacedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Never Married 2 ☐ Married 1 Yas 2X No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collega (1-4or 5+) C.S.A. Department of Army 12th 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Joseph H. Roth Soltysiak Augusta 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Donna M. Rasinski Whitaker 151 Crosstie Drive Stewardtown PA. 17363 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, State 20a Mathod of Disposition Data Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus Cemetery 5/19/2000 Baltimore Maryland 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensee Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221 23a. Part1. Entar the disease, or combilications that ceused the death Do per anter the mode of dying, such as cerdlac or respiratory arrest, shock, or haer failure. List only pre-ceuse on each line. lerotic Cardiovascular Disease Immediata Causa (Final 25 years disaese or condition resulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availebla prior to 24a. Was an autopsy performed?

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29b. Signatura and titla of certifiar

29c. Licensa number

30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print)

ST. Baltimore, 225. Militello Groome 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5654 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** May 13, Jacques Joseph Remmell 2000 8:30 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 7164 Fairbrook Rd. Baltimore Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/28/1918 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 MM 2□ F Months Deys Hours Yrs. 216-01-9857 82 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 25 No Directo Maryland Baltimore Baltimore Itserns 23s or 28s-f permit. Pages 1 and 2 should be flaed within 72 hours after death with the N Operatinent of Health and Mental Hyghen. Important: If flam 57 is marked other than "entural", or thems 23s or 288-4 any Injury or other traumetic event, the Medical Examinar must be notified 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7164 Fairbrook Road 21244 USA Funeral Race - American Indian, Bfeck, White, etc. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Insurance Agent Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Remmell Marion Horne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Remmell / Spouse 7164 Fairbrook Road Baltimore, Maryland 21244 20b. Pface of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete Lakeview Cemetery 5/17/00 Randallstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licenses 22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximete Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final archone acks diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): attending physician Box 68760, Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vitai Records, P.O. signed by t 3 Probably 4 D Onknown 1 Yee 2 No 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No nepital or Attending Physician: Thours after death.

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State Registrar

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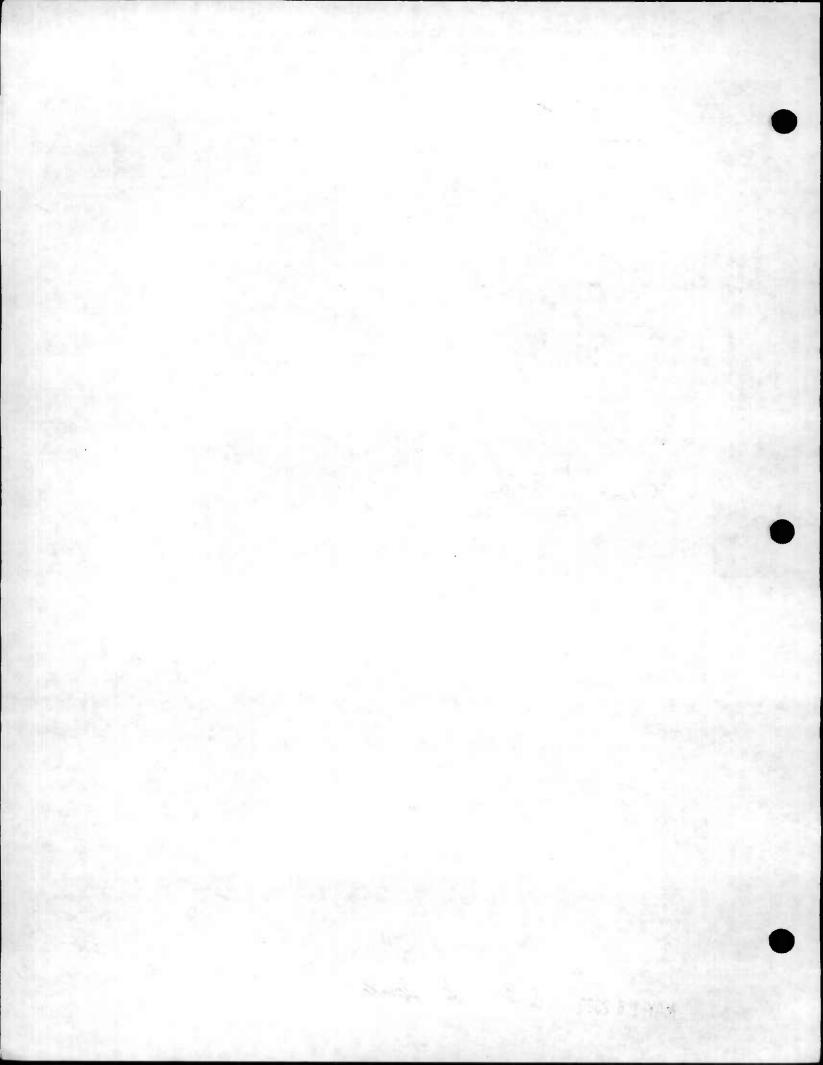
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30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

32. Registrar's Signature

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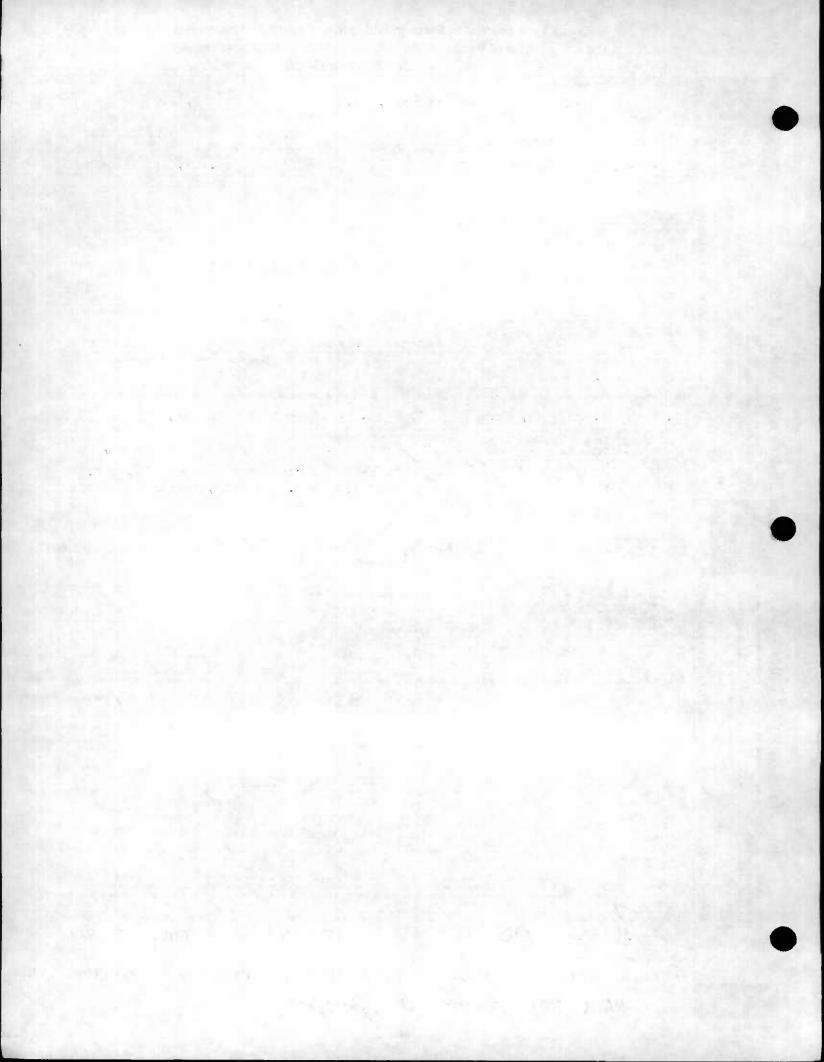


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State of Maryland / Department of Health and Mental Hygiene | 5 6 5 5

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Scherer Edythe 2000 525 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hom E (clasces 1'5 RULGERG OVIEN Novsin | Months | Days | Hours | Min. | Nov. 13, 1913 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 220-30-4096 1□ M 21 F Months 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Marial hygierie. Importants if Hear 23t or arericed orther than "natural", or itema 23a or 28a-f show any fujury or other traumatic event, the stadies if event can must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3601 Lochearn Drive U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Board of Child Care Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Methodist Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Nelson Shores Mary Magdalene Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward N. Shores (Brother) 1903 Pagham Road, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriat 2 Cremation 3 Removat from State Woodlawn Cemetery 5/12/00 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Loring Byers Funeral Directors, Inc MOR MOSSIS 8728 Liberty Road, Randallstown, MD 21133 only Dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Physician Respiratory feilare

Due to (or as a consequence of): Immediate Cause (Final /Medical disease or condition resulting in death) Examiner Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. an/Medical Due to (or as a consequence of) Physici Part it. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. anoxic encephaloxaths 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? this cartificate has 1□ Yes 2000 1 ☐ Yes 2 ☐ No al or Attanding Physician: The star death.

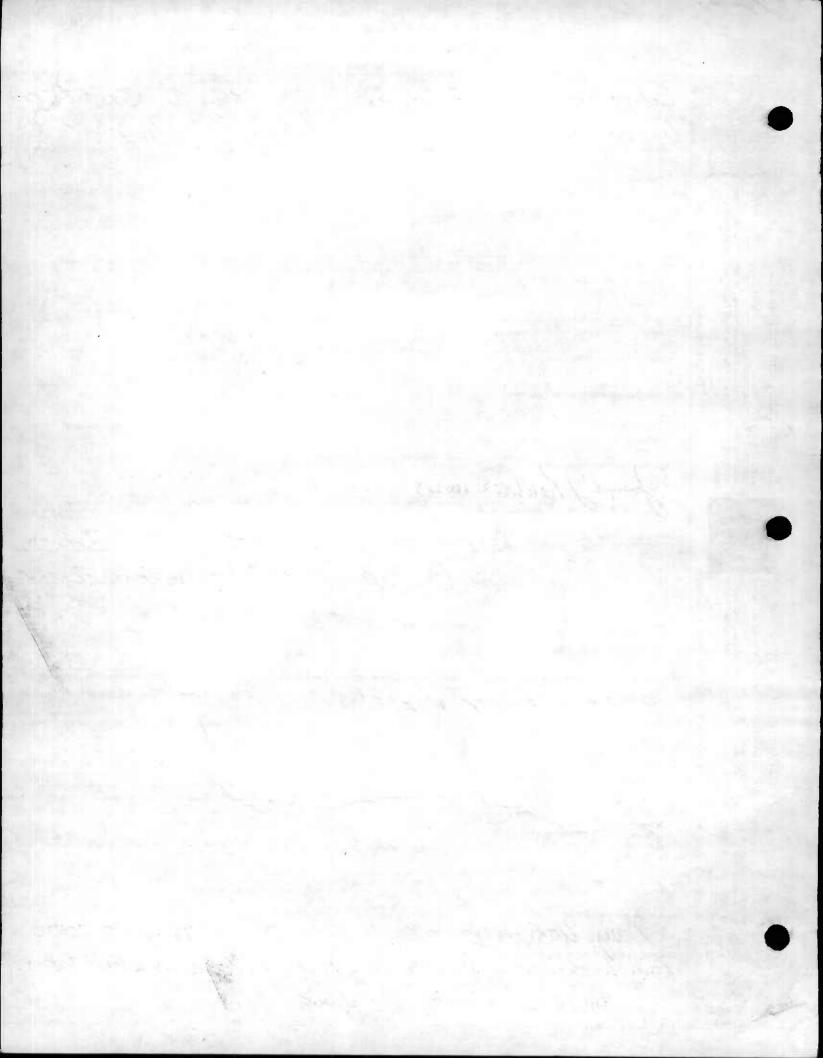
In Director: After this carificated in by the funeral director, pure the start of the start 25. Was case referred to medical 26. Place of Death (Check only one) e Hospitat: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28h Time of 28c. tnjury at Work? Certification: 1 Diffatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of tnjury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide Hospital 24 hours Funeral 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours To the Funer administery III edical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wak 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e Red Colemnis 19 Med 2108 Karlowing 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 6 2000

DHMH 16 Rev 6/95

Registrar

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 3. Time of Death 1:50 pm 1. Decedent's Nama (First, Middle Last) 2. Data of Death Year Month **Physician** Emma Jane Soffos 13, 2000 4c. County of Deeth /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Examiner Baltimore Care Center-Oak Crest Village Parkville Months Days Hours Min. Sept. 28, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 1 F Mary Land Yrs. 88 Director 212-12-4074 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2√€ No Directo Baltimore Pikesville 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21208 106 Hawthorne Avenue 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Datas: 1 ☐ Never Merried 2 ☐ Married "natural", or I 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Real Estate Agent Real Estate 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Pages 1 and 2 should be nent of Health and Mental Charles Amrhine Anna McGee 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 200 Bellmount Forest Ct., Unit 401, Timonium, MD 21093 Mary Hohne (Niece) 20b. Ptece of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removet from Stete Druid Ridge 5/17/00 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Loring Byers Funeral Directors, Inc 21. Signature of Funerel Service Licensaa 8728 Liberty Road, Randallstown, Maryland 21133 MOD J33 23a. Rn1. Ento the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heen failure. List only one ceuse on aech line. **Physician** End stage dementia, Al zheimertyke Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Couse (Disease or triury that initiated events resulting in death) Last Due to (or es a consequence of): 68760 Due to (or es a consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown Congeitive Heart 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? 24a. Wes en eutopsy 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Pro ö 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not ba determined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stele) 28a. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Furieral 29e. Certifier 1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the comple 29b. Signature and litle of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) Numels 30,82 May 14, 2000 30. Neme end address of parson who completed cause of death (ttem 23a) (Type, Print) 8300 Welter Blud Baltimore 212 34 MISSAL Mp well Am 32. Registrar's Signeture State Registrar 77 121 -DHMH 16 Rev 6/95

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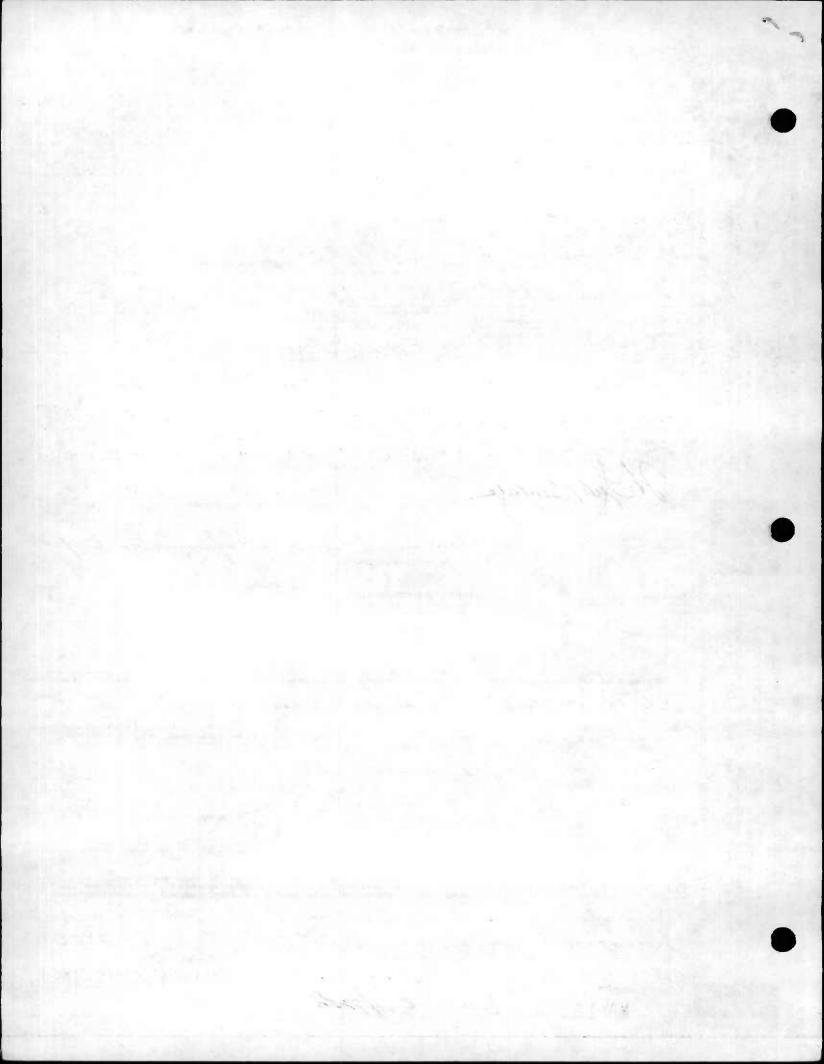
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State of Maryland / Department of Health and Mental Hygiene 1 5659

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F	19a. Informent's Neme/Reletionship		19b. M	eiling Address (Stre		or Rural Route Numb		State, Zip Code)	
	R. Taylor McLear							, MD 21204	
	20e. Method of Disposition	,	20b. Place of Di	sposition (Neme of		Dete		City or Town, Stete	
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Be	25. Wes case referred to medical exeminer?				26. Place	f Deeth (Check only	one)		
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PHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month Year 1050 **Physician** John Sparl ana May 2000 /Medical 4b. City Town, or Location of Beath 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 1105 DI HOOKINS Balti ohns more If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Hours Min. Month, Day. 5. Social Security Number 6. Se 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 217-12-7204 Usual Residence of Decedent 10 M 20 F Yrs. Yazylana Director Town or Location 10a State 10b Counts 10c. City. 10d. Inside City Limits wow il Hygiene. other than "naturel", or flerma 23a or 28a-f ehov vent, the Madical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S.
Armed Forces?

1 Dayas 2 □ No
If Yes, Giva
Year or Datas: Funeral Race - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status specify: White 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eederal GOVERNIUM Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked oths eny Injury or other treumatic event, pages. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 ant's Name/Relationship #ype, Print) 19b. Mailing Addrass (Street and Number or Rural Route Nu City or Town, State, Zip Code Md 21234 101 20b. Place of Disposition (Name of cemetery, cremetory or other ple 20a. Method of Dispos 20c. Location - City 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Nama end Addrass of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximata Intervet Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Dua to (or as a consequence of): Examiner physicien and s the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No signed b P 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Magner of Deat 1 DNatural 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Division or Attending 5 Pending invastigation death. 1 Yes 2 No To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the forms. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certified

State Registrar DHMH 16 Rev 6/95

eath (Item 23a) (Type, Print)

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32. Registrar's Signatura

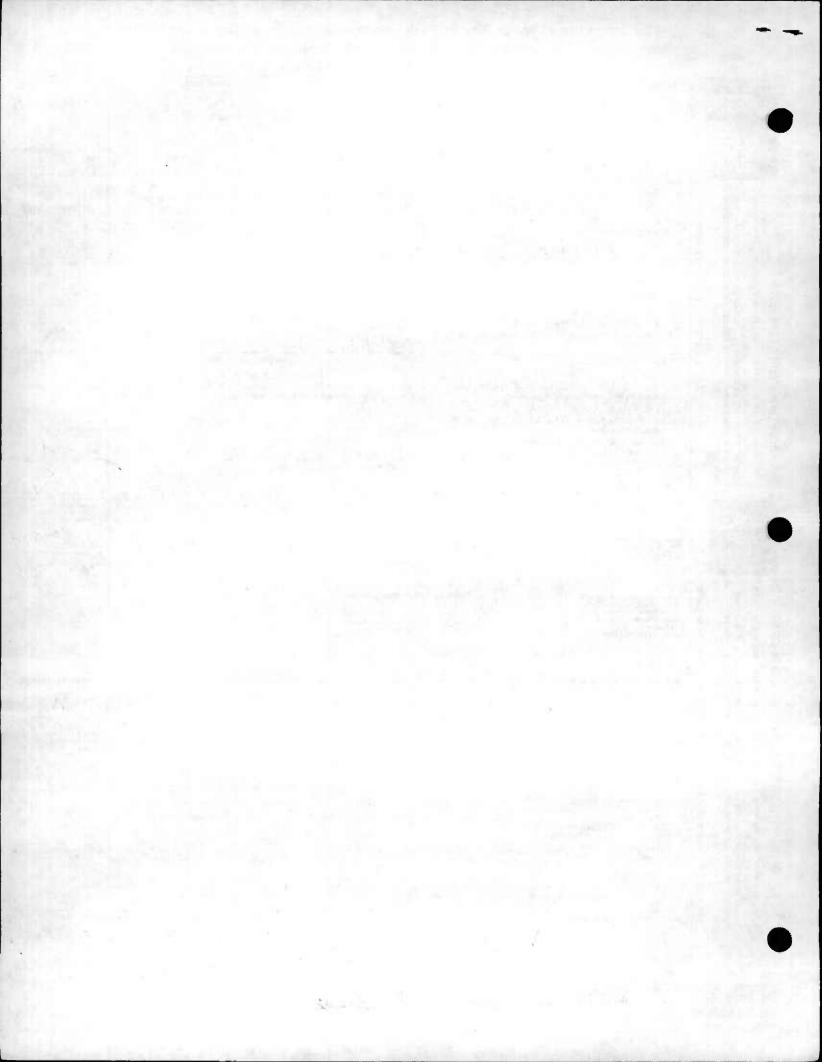
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na 31. Data filed (Month Day, Year) Hopkins Hospital 601 N cardine



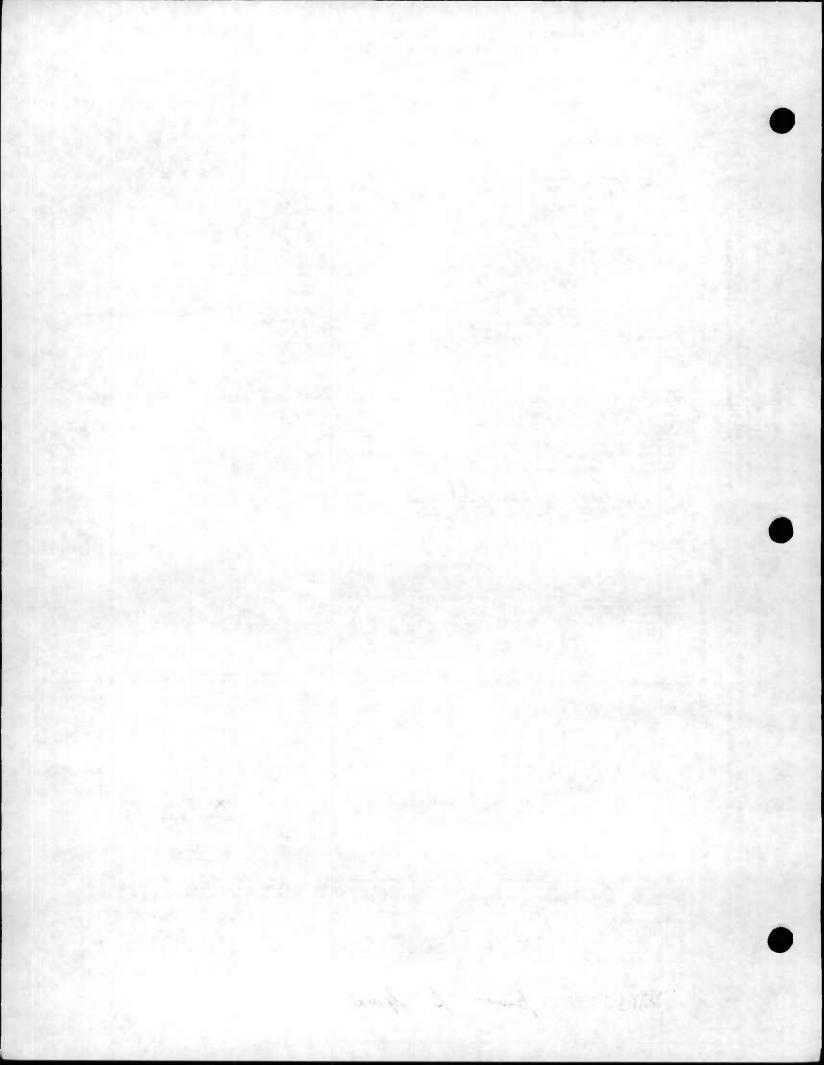
Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 5662 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Daath Month Yaar **Physician** ,2000 10:55PM EDNA E SMITH lau /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 3215 Everlasting Lane Middle River Baltimore 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) June 20,1934 Birthplaca (Stata or Foraign Country)
 PA 5. Social Security Number **Funeral** Days Months Hours 1 M 2 X F Yrs. 65 Director 159-28-6777 Usual Rasidence of Decedant 10a, State 10c. City, Town or Location 10d. Insida City Limits show ral', or items 23s or 28s-f shore Examiner must be notified at MD Baltimore Middle River 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3215 Everlasting LAne 21220 USA Peges 1 and 2 should be filed within 72 hours after death in and Mental Hygiene.
Int: If them 27 Is marked other than "natural", or itema 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Decedant Evar in U,S Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify. White Specify: Š 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Accountant Luskins Co. 2yrs 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be permit. Peges 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 Is marked oth any Injury or other traumatic ever Botal. P Fred Wilkinson Bessie Mae Crooks 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Fred A. Smith / son 3215 Everlasting Lane Baltimore Md. 21220 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Slala Data 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 5/11/2000 Baltimore Md. 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Connelly Funeral HOme of Essex Onn: 300 MAce Ave. Baltimore Md. 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximate Interval Betwaen Onsat and Death **Physician** /Medical Heart Failure Immediata Causa (Final Months disaasa or condition rasulting in daath) Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medicai Dua to (or as a consequence of): 23b. Did tobacco use contribute to the causa of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown 20. t. Be Completed by Records. The law requires 24b. Ware autopsy tindings available prior lo 24a. Was an autopsy performed? complation of ceusa of death? Metastare 1X Yas 2 No 1 Yas 2 No of Vital Physician: 25. Was cesa rafarred to medicel axaminar? 26. Place of Death (Check only one) Othar: 4 ☐ Nursing Homa 5 Rasidance 6 ☐ Othar (Specify) Hospital: 1 Yas 2 No edical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatiant this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Dascribe how injury occurred After 1 or Attending Division 1 Naturat 2 Accidant 5 Pending investigation r death. 1 ☐ Yas 2 ☐ No after death 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 28a. Place of tnjury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled To the Hospital Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and fills of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) 05.09.2000 50040 30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) MAY 1 6 2000 32. Registrar's Signatura

DHMH 16 Rev 6/95

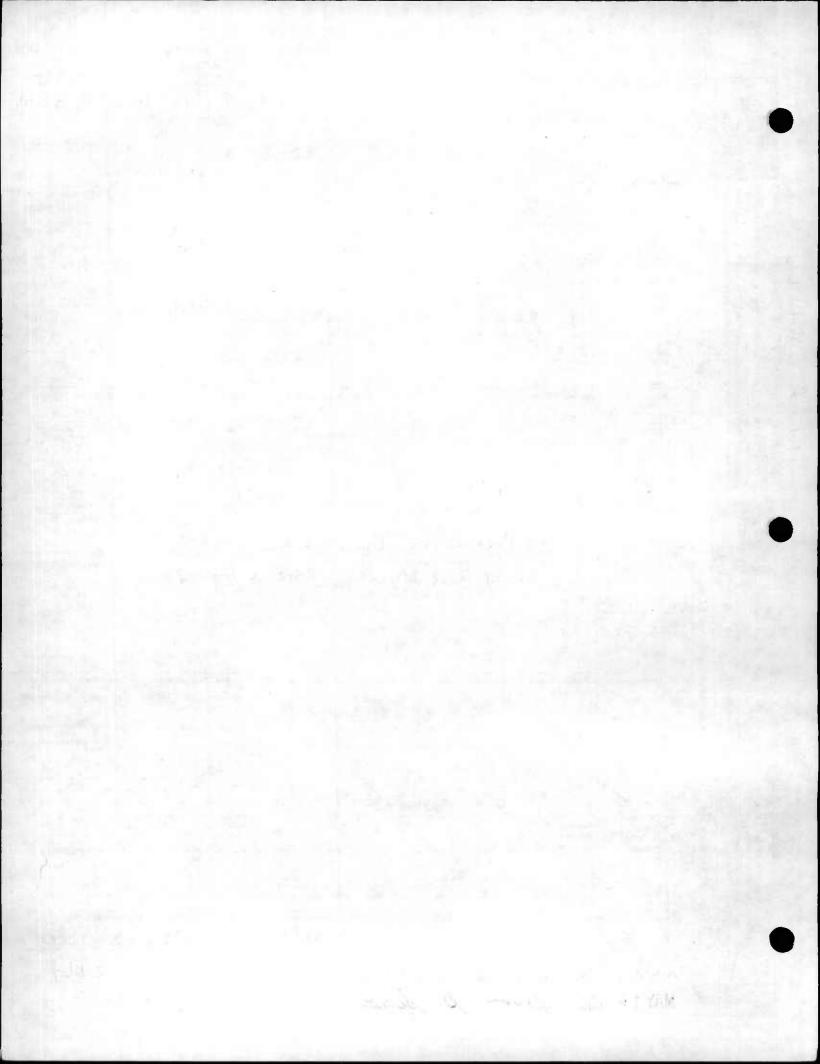
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:18P.m. Anna Genevieve Solomon 2000 12 /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner North Arundel Hospital Association Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Yrs. 216-24-2568 Dec. 8, 1918 Director Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow traumetic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 death with or Nems 23a Funeral 8657 Veterans Highway 21108 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 and 2 should be nent of Health and Mental marked Ear1 Pumphrey Josephine Phelps 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) parmit. Pages 1 and 2 sh Department of Health and Important: if Itam 27 is m any injury or other traum Bernice Chenoweth- cousin 429 Maple Lane N.W., Glen Burnie, Maryland 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removel from Stete Glen Haven Mem. Park 5/16/00 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA. 21. Signeture of Funeral Service Licensee 1101234 1 Second Avenue, SW, Glen Burnie, MD 21061 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting In death) PHLMONARY Embousin /Medical **Examiner** Due to (or es e consequence of): Physician/Medical Examiner MONET RESGIRATURY ed by the attending physician and detached for use as the bunaf-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760. thet initieted events resulting in death) Last Due to (or es e consequence of): P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of death? 20 No this certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 10 funeral Certification: 27. Mannet of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural within 24 hours after death.
To the Funeral Diractor: A completely filled in by the ft death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated. Medicai 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner steled. \$ 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2000 30 Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 21061 Guing. 31. Dete filed (Month, Day, Year)
MAY 1 6 2000 32. Registrar's Sign State oaks Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 5 6 6 4

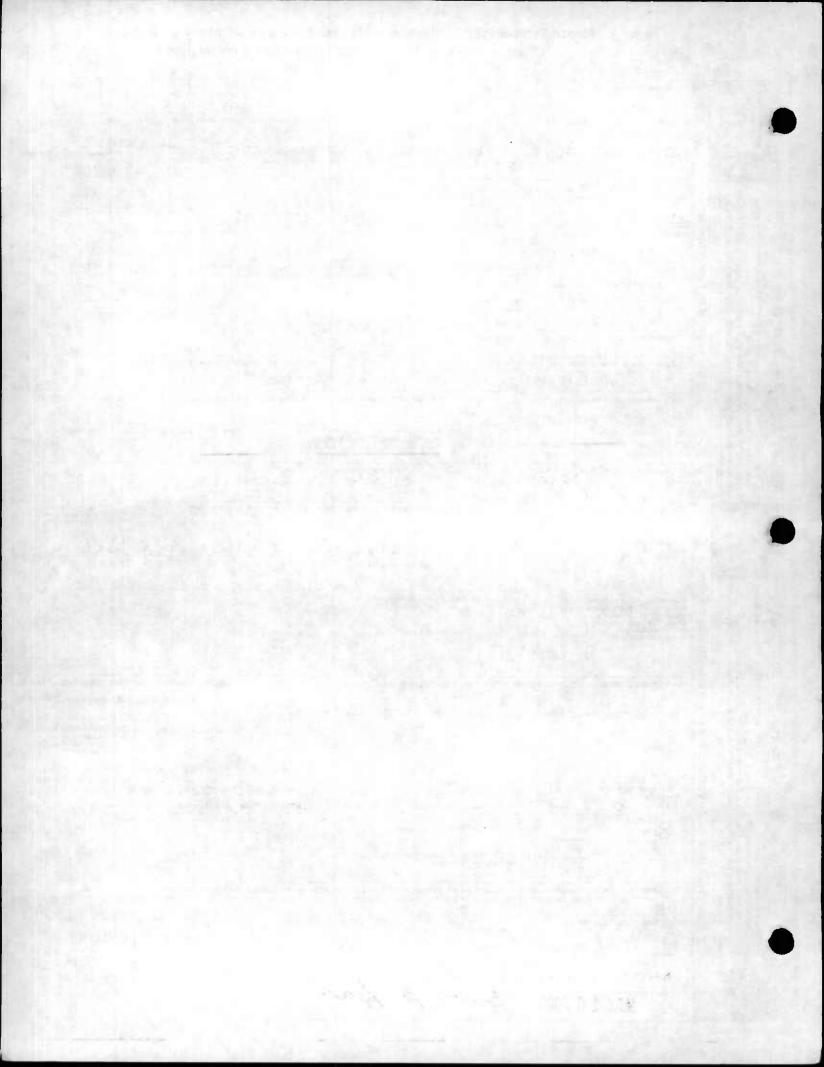
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Year **Physician** 11:00 Am Carrie MA 2000 Evelyn Snyder /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 537 Munroe Circle If Under 1 Year If Under 24 Hrs. Hours Min. Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 1 F Vrs 220-14-9039 75 Aug. 16, 1924 Maryland Director Usuel Rasidence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location Worls 10d. Inside City Limits them 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinat must be notified at 1 □ Yes 2 N No Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 537 Munroe Circle 21061 Funeral U.S.A. death 11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, Whita, etc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Secretary Baltimore City Police 17. Fether's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) John Snyder Marie Urban 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia J. Reffitt- Cousin 1132 Skyway Drive, Annapolis, Maryland 21401 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5/17/00 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Singleton Funeral Home, PA. V101234 1 Second Avenue, SW, Glen Burnie, MD 21061 3. Cuy 23a. Pert1. Enter the diseasa, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician /Medical Immediate Cause (Finel disease or condition rasulting in death) inkhown Examiner Due to (or es a consequence of) Examiner The lew requires that the death certificeta be asscuted Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es e consequence of): Box 68760, attending physician for use as the hine Physician/Medical Dua to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? After this cartificate has been signed by funeral director, page 2 should be detac 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Ware eutopsy findings eveilable prior to complation of causa of death? Completed 24e. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 1 No of Vital Attending Physicien: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 ANO Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred Division 1 DeNaturel 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be determined ne Hospital or Attent no 24 hours after der we Funeral Directo pletely filled in by the 3 Sulcide 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 12 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and mannar es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Certifian Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) MAY, 15, 2000 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 7845 approop NU SUITE 20) GLEWBURNE MO 2106/ c raminte eten MU 32. Registrar's Signature 31. Data filed (Month, Day, Year) MAY 1 6 2000

Registrar

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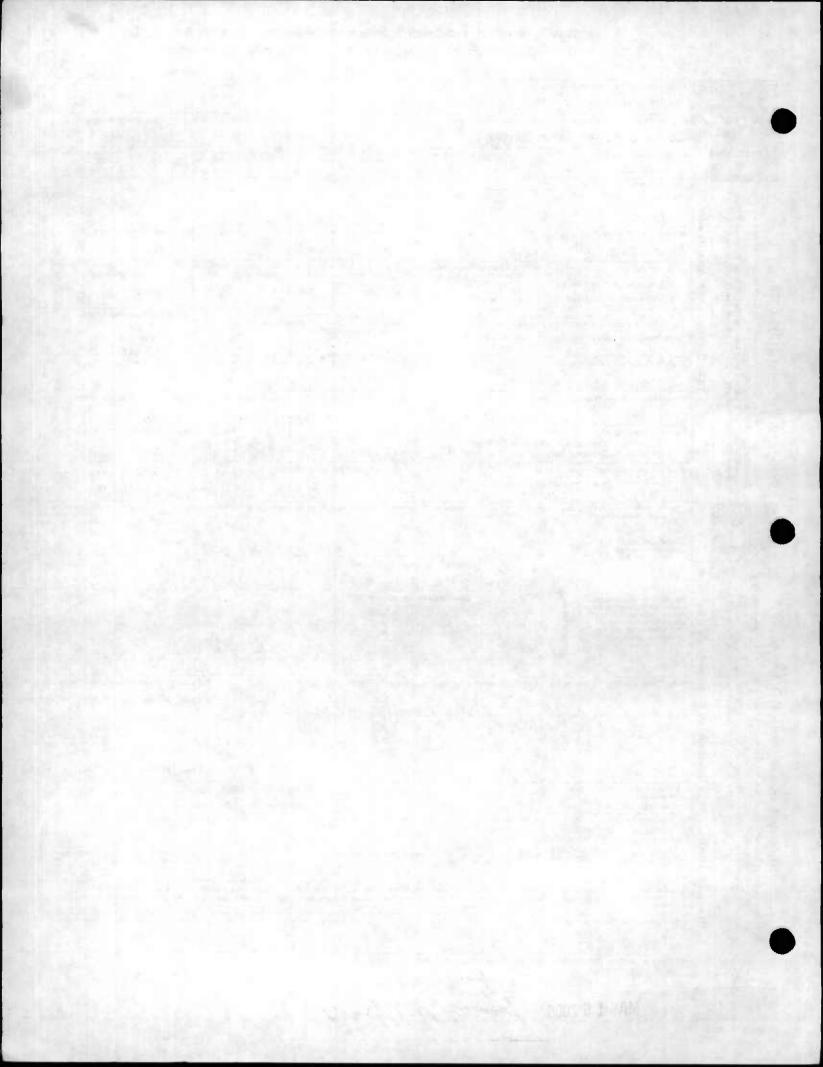
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MARYLAND	N/A		E	BALTIMO	RE CITY				1 41	1 X Yes 2
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3 D Widowed	4 ☐ Divorced	If Yes, Give Yeer or Det	tes:	1	☐ Yes 2 XX	Specify:		Spec	BLA	ACK
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17. Father's Name		ist)			7/1/10	18. Mother's Nan	ne (First, Middle	e, Meiden Sume	eme)	
CLYDE	A SMITH					LUCY	I GOUGE	Н		
19a. Informant's N	Vame/Retationship	(Type, Print)		19b. Mailing	g Address (Street	et and Number or Ru	iral Route Numb	ber, City or Tow	m, State, Zip	Code)
Albert	Smith/B	rother		1418	Argvle	Avenue, E	Baltimor	re, Mary	vland	21217
20a. Method of Dis	sposition			Place of Dispos	ition (Name of	52 459 - 1	Date	20c. Location		
	5 ☐ Other (Spe	Removel from S	tate N	VEW CATHE	DRAC CEME	TERY	5/19/2000 5-17-00	BALTI	MORE. M	MARYLAND
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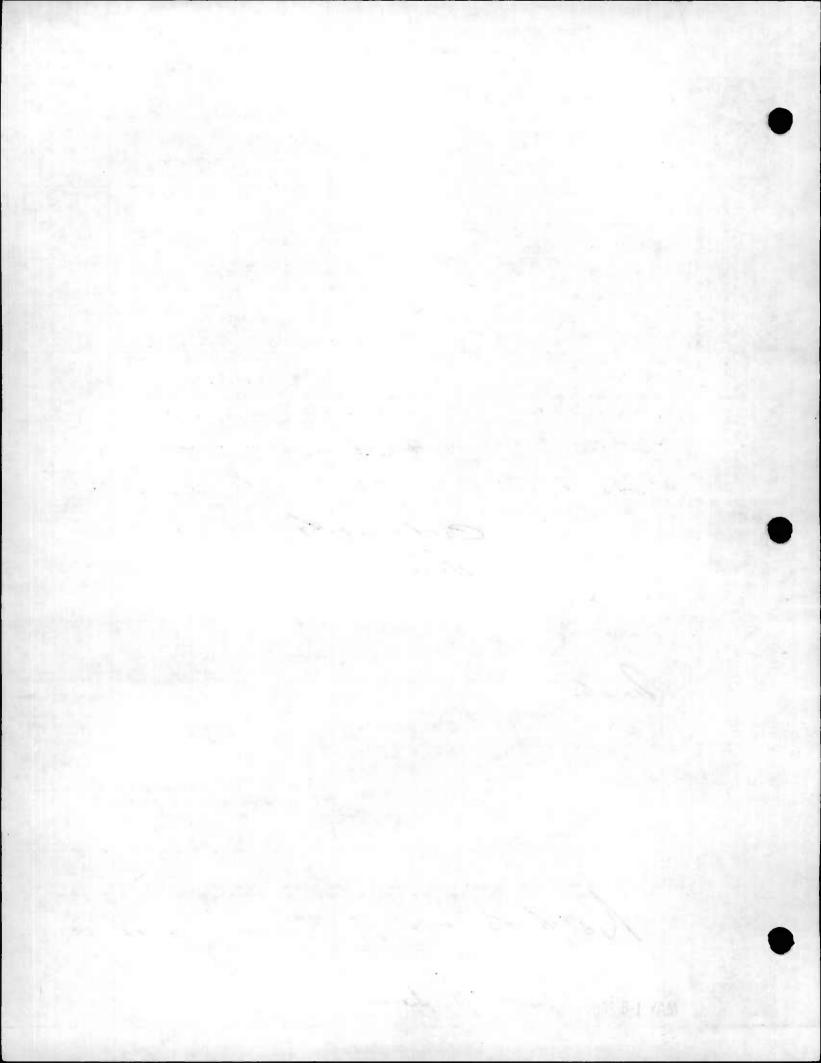
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DHMH 16 Rev 6/95



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5	30. Nama and addrass of person who	completed causa of	daath (Item 23a	(Type, Print)						
	Eddie Nakhuda	a. M.D. 2	300 Dul.	aney Val	leu F	d Time	onium, M	d 21093		

NAME: SUTER, FRANCIS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #17 PER F.H. G78 5-16-00 WR. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3 Time of Death 219 pm **Physician** 2000 /Medical 4e Facility Neme (If not institution, give street and number) th City, Town, or Location of Digital 4c. County of Death Examiner r 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Sociel Security Number If Under 1 Year 6. Sex 1 1 M 2 □ F 9/ Birthplece (State or Foreign Country) **Funeral** Deys 219-54-3670 Usual Residence of Decedent Director ano 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mantal hygiene.

Department of Health and Mantal hygiene.

Inportant: if item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Medical Experies must be notified and once. 1 Yes 2 No Funeral Director larylang 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Raca - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) nowr 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address, (Street and Number or Rural Route Number, 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other pleca) 20c. Location - City or Town, Stete 1 Buriai 2 Cremation 3 Removel from State 4 □ Donetion 5 □ Other (Specify) 21 Signiflum of Funeral Service Licens 22. Name and Address of Fecility Joseph 2222 North true Sal 23a. Part I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, about on heart factors. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finei disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last The lew requires that the deeth certificate be execu Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causs of death? 1 ☐ Yss 2 ☐ No 3 □ Probably 4 D Unknown þ director, page 2 should be 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Be Completed After this certificate hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA the funeral 28c. Injury et Work? 27. Menger of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel Injury death. 1 ☐ Yes 2 ☐ No after death 2 Accident To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dev. Year)

State Registrar

DHMH 16 Rev 6/95

MAY 1 6 2000

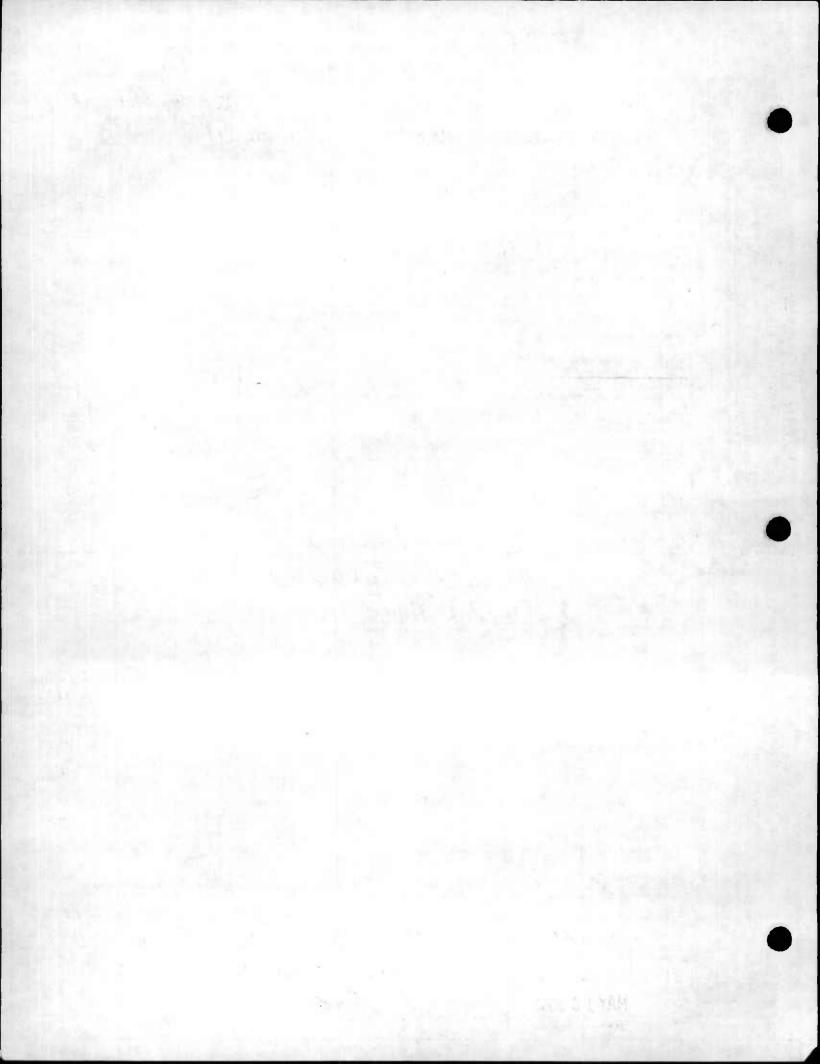
31. Dete filed (Month, Dey, Year)

Macem,

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

A matur Nacem, M.D. & Maryland 32. Registrer's Signeture

H Rower



lease Type	or Print in Black Indelible ink.	Assure All Copies	Are Legible.	grang	, .	1	-
State	e of Maryland / Department of H	ealth and Mental Hy	giene] [51	0 8	0	-

an	AMEND ITEMS 1. Decedent's Nama (First, Middle, Lasi		EO CE	rimouto	or Dealir		of Death	No.	1 2	Time of Death
				T/,	11	Mont	h	Day	Year 3.	
cal _	MYIESHA 4a Facility Name (If not institution, give			14	NSTAL	MA MA		2000 4c. County (of Death	1207 PM
ner						IMORE		40. Codiny	1)/0	
	ST.AGNES HOSPITZ 5. Social Security Number 6. Se		yrs. last birthday)	If Under 1	Year If Undar		of Birth		9. Birthplace	(Stata or Foreign
	217-57-3901 11	□M 200 F	O Yrs.	Months	Days Hours	Min. (Mon	L 14	2000	MAR.	VLAND
-	Usual Residence of Decedent						- 17	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	10a. State 10b. County	10	c. City, Town or Lo	ocation			1			Inside City Limits I ✓ Yes 2 No
Director	MARYLAND A	IA		10	ALTIM	ORE C	17			2010
ā	10e. Street and Number			10f. Zip C	000	A 0	10g.		hat Country?	
Funeral	0933 KOK	12. Was Decedent Eve	AD 13	Was Deceda	ot of Hispanic Original	of 9 nin2 (Specify Yes	or No-	U.5.	- Amarican I	ndian
Fun	11. Marital Status 1 Never Married 2 Married	Armed Forcas?	1000		nt of Hispanic Original Cuban, Maxican	Puarto Rican, et	c.)		k, Whita, atc.	
	3 ☐ Widowed 4 ☐ Divorced	If Yas, Give Year or Dates:	100	1 □ Yes 2	No Specify:			Specify:	By MA	Y
9	15. Decedent's Edu	ucation	16a. Dece	dent's Usual	Occupation	ad consistence	168	o. Kind of Bu	siness/Indust	ry
Completed by	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	done during most retired)	or working			1 ,	
5	0				NIA			/	VIA	
Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, M	fiddla, Mai	den Sumame	θ)	
9	MICHAEL		UNSTA	-LL	CH	ERON			HIL	L
	19a. Informant's Name/Relationship (T		19b. Maili	ing Addrass (Street and Number	r or Rural Routa I	Vumber, C	ity or Town,	State, Zip Co	
(CHERON HILL	(MOTHER	Ob. Place of Disp	33 K	OKEBY	KOAD	BAL	TO, A	10,2	1229
1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I		cemetery, cre	matory or oth	er placa)	Data			City or Town,	
1	4 □ Donation 5 □ Other (Specify)	METRO	CRE	MATOR	45-19.	00 8	DALT	0, M1	PRYLAND
	21. Signature of Euneral Service Licens	1. 7/1	1 . 2	2. Nama and	Address of Facilit	BROU	こんじ	R. FL	INER	AL HOM
	Lucial 1	1. Welle	10	2140	N. FU	LTON A	VE.	BALT	O, HL	1.2121
	23a. Part1. Enter the disease, or comp shock, or haart failura. List only of	plications that caused the ona causa on each lina.	daath. Do not an	ter the mode	of dying, such as				Ap	proximata erval Between
		PNEUMO	NIA WITH	DEHYD	RATION				On	sat and Death
	Immediate Cause (Final disease or condition	a								
7	resulting in death)	Dua	to (or as a conse	quanca of):					1	
Ě		b							1	
Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as a conse	quance of):						
Sair	Cause (Disaase or injury that initiated evants	C	10 /02 00 00 00000							
8	rasulting in death) Last	Due	to (or as a consec	quarica or).						
2		d								
Cla	Part II, Other significant conditions co	entributing to death but no	ot resulting in the u	inderlying car	use given in Part I	23t	. Did toba	cco usa con	ntributa to the	cause of death?
							1 Yes	2□ No	3 Probabi	y Junknown
, hys								The		
								utonev	24b. Wara availat	outopsy findings ole prior to
à l						24a	. Was an a	d?		ation of causa
by						24a	. Was an a performe	d?	compli of daa	In r
by				1.8		24a	. Was an a performe	d? 2□No	of daa	as 2 No
Completed by	25. Was case referred to medical			14	26. Place	24a of Daath (Check	performe 10 Yes	d?	of daa	
o Be Completed by Phys	examiner?	Hospital: 1 ☐ Inpatient	XX ER/Outpatie	ont 3⊡ DOA	Other:		performed Yes	d?	of dea	
To Be Completed by	examiner? No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	28b. Time o		Other: 4 Nu	of Daath (Check	performed for the second only one) Rasidano	d?	of dea	
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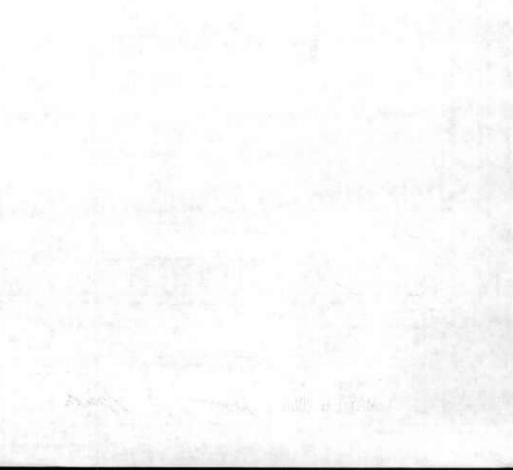
	ne (First, Middle, Las	7 PER MEO G783	Certificate of De	2.	Reg. No. Dete of Deeth Month Day	3. Time of Death
ical Elia	S	leiber		r	May 11,2000	9:44 P.M.
itei	ilf not institution, give rrapin Roa			City, Town, or Location	,	
5. Social Security N	Number 6. S	ex 7. Age (In yrs. last I	. Months Devs 1	Onder 24 Hrs. 8.1	Date of Birth Month, Day, Yearh	9. Birthplece (State or Foreign Country)
Usual Residence of	2 10201	M 20 F 46	Yrs.	//	ay 15, 1953	New York
10a. State	10b. County	10c. City, To	wn or Location	,		10d. Inside City Limits
Maryland	Montgo	mery Si	luer Spi	ing	40- 62	1⊠Yes 2□No
10e. Street and Nu	Terr	-apin Rd	10f. Zip Code V	16	10g. Citizen of V	< A
I. Marital Status		12. Was Decedent Ever In U.S. Armed Forces?	13. Wes Decedent of Hisperit Yes, specify Cuban, M	enic Origin? (Specify Mexican, Puerto Rica	Yes or No- 14. Race	a - American Indian, ck, White, etc.
1 Never Marr	11	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	_ 4	Specify:	Specify	1.1
	15. Decedent's Ed		ia. Decedent's Usual Occupatio (Give kind of work done duri life. DO NOT use retired)	n na most of working	16b. Kind of Bu	usiness/Industry
Elementary/Seco	cify only highest gra- ondery (0-12)	College (1-4or 5+)	- 1 1 .	1) citar	Tolovi	cian Maule
7, Father's Name	(First, Middle, Last)	7	roqueer/u	. Mother's Name (Fi	rst, Middle, Maiden Surner	$\frac{57071}{100}$
Milto	on Te	iber		Linde	Resch	nnV
19a. Informant's N	lame/Relationship (7	Type Print) (mother) 1	9b. Malling Address (Street end	Number or Rural Ro	oute Number, City or Town,	State, Zlp Code) 85718
20a. Method of Dis	position	20b. Place	of Disposition (Name of	10 MITAY	910 / 20c. Location -	City or Town, State
	☐ Cremation 3 ☐ 5 ☐ Other (Specify	Hemoval from State	tery, crematory or other place)	metery 5/	Stoon TUCS	on. Arizono
21. Signature of Fi	uneral Service Licen	see OIN	22. Neme end Address of	The control of	Funero	1 Hame
you	lepk	d. Kuss	2225 M.	North	Ave Bal	to. Md. 21216
shook, or her	List only	ofications that caused the death. Done ceuse on each line. HYPERTENSIVE	o not enter the mode of dying, s ATHEROSCLEROTI	C CARDIOV	Spiratory arrest, ASCULAR DISE	ASE Approximete Interval Between Onset and Death
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resulting in death)		Due to (or as	a consequence of):			
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resulting in death)	Last	C	a consequence of):	n Part I.	23b. Did tobacco use con	ntribute to the causs of death
resulting in death)	Last	CDue to (or es a	a consequence of):	n Part I.	23b. Did tobacco use con 1 □ Yss 2 No	ntribute to the causs of death
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MAY 20 20.30 Johnson D. Janes

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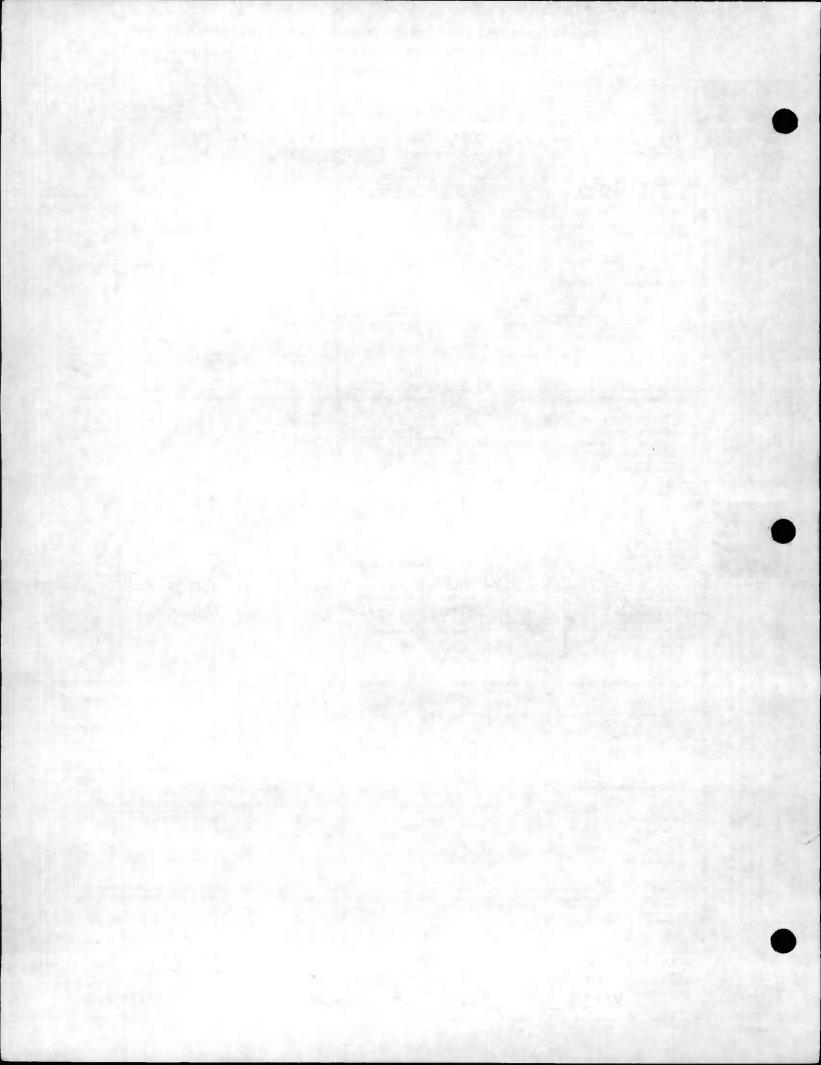
	1. Decedent's Nar	na (First, Middla, La	st)					2. Data of Dea		3. Tima of Death
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icai iner	4a Facility Nama	(If not institution, giv	a street and number))	- And Selection		4b. City, Town, or	Location of Death		
	Sinai	Hognita	1				Baltimo	ore	N/A	
		Hospita Number 6.5		ga (In yrs. lest	M	f Undar 1 Yee tonths Day:	r If Under 24 Hrs	8. Deta of Birt	h v, Year)	Birthplace (Stata or Foreig Country)
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	10a. Stata	10b. County		10c. City, T	Town or Locati	ion	20 10 11			10d. Inside City Limit
	Md	N/A		Bal	to					MOWas 2□N
Director	10e. Street and No	umber		1		101. Zip Coda			10g. Citizen of Who	at Country?
1	4310 E	thland A	venue			21207			USA	
ľ	11. Maritel Status		12. Was Decedent Armed Forces?	Ever in U,S.	13. Was	s Decedant of	Hispenic Origin? (5 ban, Maxican, Puer	Specify Yes or No-	14. Reca -	Amaricen Indian, Whita, atc.
		ried ZX Married	1 ☐ Yas 2 ☐ H If Yas, Give			Yas 2 N		,	Specify:	Black
	3 ∐ Widowed	4 Divorced	Yaar or Datas:							
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State of Maryland / Department of Health and Mental Hygiene 15672

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Margaret Trovato May 2000 13, 11:20 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner Eastpoint Rehabilitation Center N/A Baltimore If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Director 212-22-9636 91 Oct. 26, 1908 Maryland Usual Rasidence of Decedant the Meryland 10a. State 10b. Count 10c. City. Town or Location 10d Inside City Limits r than "naturel", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore N/A 10g, Citizan of What Country? 10e. Street and Number 10f. Zip Code 7612 Berkshire Road 21224 U.S.A. Funeral Was Decadent of Hispanic Origin? (Specify Yes or No-tif Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amaricen Indian, Black White atc. filed within 72 hours aftar 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home permit. Peges 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic avent, in 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Robert Dixon 2 Mary McNamee 19a. tntormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Roberta Hutchins- Niece 7612 Berkshire Road, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town State Date 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 5/17/00 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licensee Singleton Funeral Home, PA. 1 Second Avenue, S.W., Glen Burnie, MD 21061 Approximate Interval Batween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ARREM PURAJE RS Cropo VARLY Examine Dua to (or as a consequence ot): Examine physician end the burial-transit certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ot): 68760 Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequence ot) 80 Box Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DENENAK þ Records, 24b. Wara autopsy findings available prior to complation of ceuse ot daath? 24a. Was an autopsy performed? Completed has 1 ☐ Yes 280 No 1 ☐ Yes 2 No certificata of Vital 25. Was cese reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division Hospital or Attending 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Decrifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifiar (Check only one) 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) mathers D45757 2000 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) Matthew McNabney, MD 5505 Hopkins Bayview Circle, Baltimore, Maryland 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 6 2000 Registrar

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State Registrar

Stephen 5, 31. Date tiled (Month, Dey, Year) MAY 16 2000

Radentz 2. Registrar's Signature Berner B.

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State of Maryland / Department of Health and Mental Hygiene

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	ARLENE	AM	END ITEMS: #23 PAR	State of Maryland	/ Department of I	lealth and Death	Mental Hyg	jiene	156	76
			1. Decedent's Neme (First, Middle, Last)				2. Date of Dee	th		Time of Death
	Physic /Medi		MARLENE		WOOD	LON 4b. City, Town, or	Month MAY			25P.M.
زي	Exami	ner	4e Fecility Neme (If not institution, give :					4c. County	A /	٨
-	Formeral		314 S.MONROE STREI 5. Social Security Number 6. Security Number		t birthday) If Under 1 Year	BALT'IMC			9. Birthplace	(State or Foreign
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	23e		314 SOUTH 1	IONROE STA	REET .	2122	3		SA	
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5-0020	hour hour	D		Yeer or Detes:	16a. Decedent's Usuel Occup	nation		16b. Kind of Bu	15L1	TUK
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7	shoul od Me mark	ř	LUC/OUS 19a. Informent's Name/Relationship (Ty)		19b. Mailing Address (Street					
altimore, Ma	Pages 1 and 2 ent of Health a nt: If Hem 27 la ry or other trains		ELIZABETH WOOD 20a. Method of Disposition 1 Buriel 2 Cremation 3 B 4 Doneting 5 Other (Specify)		3145, MO e of Disposition (Neme of etery, cremetory or other ple	ce)	ST. BA	20c. Location -	City or Town,	Stete
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x 68760	certificate b nding physic use as the b	Medical	Cause (Disease or injury that initialed events resulting in death) Last	Due to (or as	s a consequence of):					13.1
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	To the Hospital or within 24 hours att To the Funeral Dis completely filled in	Medical	29e. Certifier (Check only one) 1 Certifying Physical Example one)	ician: To the beet of my knowle or: On the basis of examination and panner stated.	edge, death occurred at the ti n and/or investigation, in my	me, date and plac opinion, death occ	e, and due to the d urred at the time, d	ause(s) and ma date end plece,	anner es steted end due to the	l. cause(s)
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	(1)	-	30. Name and address of person who co	melited cause of death (Item 23	3a) (Type, Print) 111 Penn	Street,				1201
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Registrar
DHMH 16 Rev 6/95

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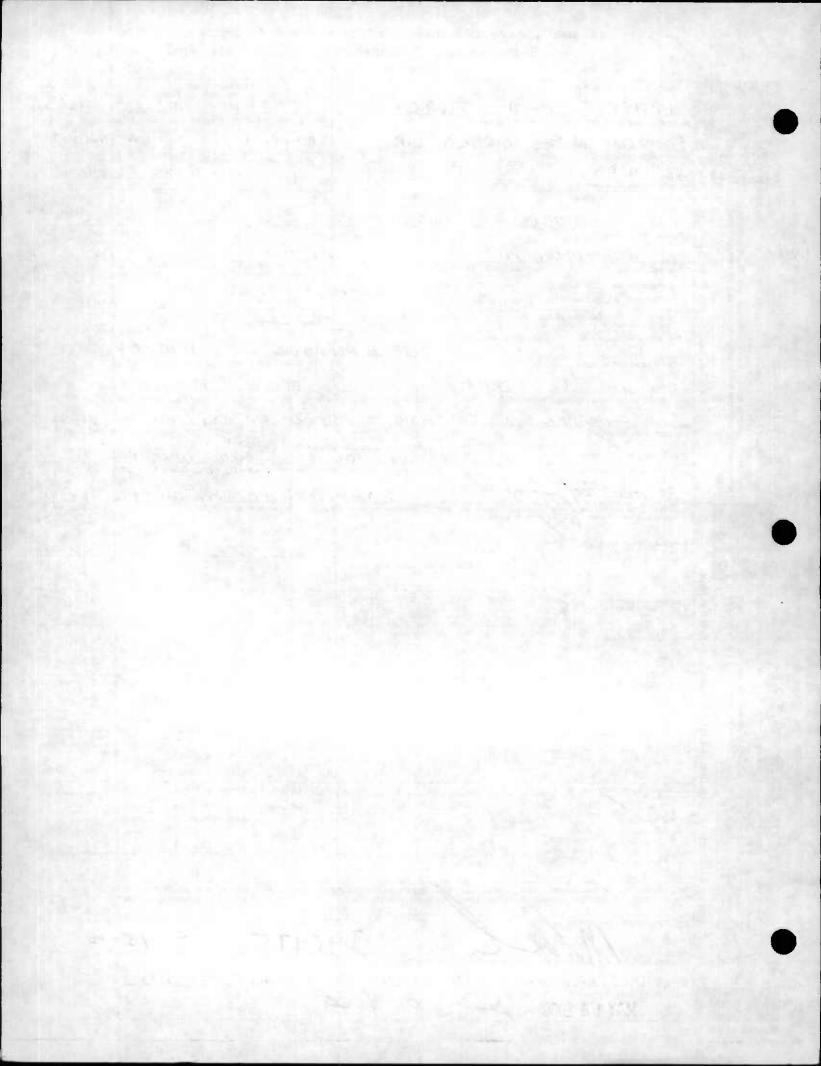
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) Dey Month Yaar **Physician** MILDRED MAY 105 AM MARIE WUOD 15 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WOODS NURSING CTR ROSEDALE FRANKLIN If Under 1 Yaer | If Under 24 Hrs 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) 5. Social Security Number 6. Sax 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 F Yrs. MD Director 212-09-9307 MARCH 30, 1913 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Director MO PARKVILLE BALTINORE must be notified 10a Street and Number 10f. Zip Coda 10n. Citizen of What Country? 21234 OLD HARFORD 8800 RD U.S.A. Funeral 14. Raca - Amarican Indien, Black, Whita, atc. 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status hours after 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Nevar Married 2 Married ò 1 Yas 2 No Specify: altimore, Maryland 21215-0020 ď Specify. 3 ₩idowed 4 Divorced WHITE Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) YOUNGS filled within Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) 12 OFFICE MANAGER MENS & BOY'S STORE 18. Mothar's Neme (First, Middla, Maidan Sumama) 17. Father's Nema (First, Middla, Last) Pages 1 and 2 should be III the ord of Health and Mental H fant: If Nem 27 is marked off items or other traumatic even Be SADOFSKY Lo F. M. GEORGE BERTH MILLER 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) PERRYHAU MD. 21336 Data 20c. Location City or Town, Stele (TAIL SHANAHAN NIECE 4211 HOLLOWSARINGS LN. 20b. Place of Disposition (Name of cometary, cramatory or other place) 20a. Method of Disposition Data MAY 15 , 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) FOREST HILL BELAIR - P.A. 2000 22. Name and Address of Fecility EVANS FUNERAL CHAPEL 21. Signetura of Funeral Service Licensee 21234 8800 HARFORD PD. PARKVILLE, MD. 23a. Por 1. Enter the diseas shock, or heart failure. Approximeta Interval Between Onsat and Death ns thet caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sause on each line. **Physician** Immediata Causa (Finel disease or condition rasulting in death) /Medical . CVA 3 MONTHS Examiner Due to (or es e consequenca of): Examiner sician end burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in daath) Last Dua to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Dua to (or as a consequence of) 88 950 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24a. Was en autopsy performed? Wara sutopsy findings available prior to Completed complation of causa of death? page 2 s 1 ☐ Yas 2 ☑ No 1 Yas 2 No of Vital Physician: 25. Was casa rafarred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 1 Natural Division 5 Pending invastigation after death.

Director: Affine by the fur 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Numbar or Rural Routa Number, City or Town, State) 28a. Place of Injury - Af home, farm, street, factory, offica building, atc. (Specify) 4 Homicida 5 To the Hospital within 24 hours of To the Funeral Completely litted Houpital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: My the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifiar Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. Licensa number 5-00 30. Name and address of person who completed cause of daeth (Itam 23a) (Type, Print) BALTIMORE, MD. 21222 AVE. MOHAMMAD RAHWAMA MD 6730 HOLABIRD 31. Data filed (Month, Day, Yaar) 32. Regisfrar's Signatura State MAY 1 6 2000 Registrar

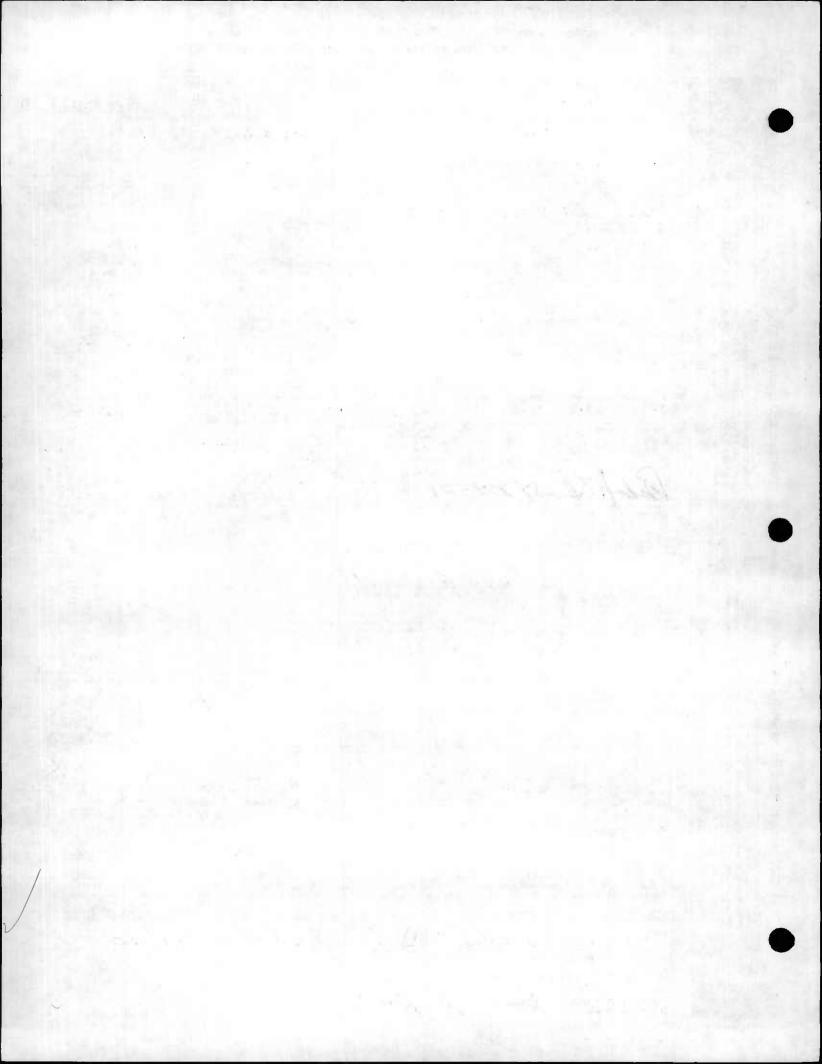
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1 21215-0 led within 72 ho bygiene. Wer than "natura At, the Medical.	15. Decedent's E (Specify only highast g	Education rada completed)	16a	Decedent's Usual Occup (Give kind of work done life, DO NOT use retire	during most of working	19	6b. Kind of Bu	siness/Indu	ustry
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B start	17. Fathar's Nama (First, Middla, Las ERNST WILHELM	()		THAT I	18. Mother's Nama GEOGIAI		laidan Sumam	a)	495
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Baltimore, n emit. Pages 1 and Separtment of Health Important; if tem 27 iny injury or other table.	20a. Mathod of Disposition 1 Number 1 Communication 1 Number 2 Number 2 Number 3 Number 3 Number 2		cerneta	d Disposition (Nama of ry, cremetory or other ple SON FORES!	r 5	(200)	OC. Location -		LLS, MD
Depart Depart Import any inj acce.	21. Signature of Funeral Service Lice	Mod &	521	CHARLES 6224 EAS	ss of Facility S. ZEILI STERN AVI	ER & SO	ON, IN	C.	. 21224
Physician /Medical Examiner	23a. Part1. Enter the disease, or cor shock, or heert feilure. List onle Immediate Causa (Final disease or condition resulting in deeth)	a. Lun	e.	ancer consequence of):		r raspiratory arra	st,	1	Approximata Intervel Between Onsat and Death
rificate be executed in physician and a sa the burial-transit	Sequantially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last	c	Due fo (or as a	consequence of):	<i>)</i> <u>e</u>				
The cords, P.O. Box The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use Completed by Physiclan/N	Part II. Other significant conditions	contributing to death but	t not resulting i	n the underlying causa giv	ven in Part I.	23b. Did to			the cause of death?
The law requires cate has been sign. page 2 should be						24a. Was ar perform		ava	ra autopsy findings ilable prior to apletion of causa leath?
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VILA ifclan: certific rector.	25. Wes casa rafarred to medical axaminar?	Hospital:		utpatient 3 DOA Oth	26. Place of Death				
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	1 Yas 2 No 27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Date of Injury (Month, Day	28b.	4 DUNUISING HOR	na 5□ Rasida 28d. Describe ho)	
DIVISION of the or Attending P ins after death. The birector: After the did in by the funers Certification:	3 Suicida 6 Could not letarmined	DO Dian of taken		arm, street, factory, office	2	28f. Location (Str City or Town	reat and Numb , Stata)	ar or Rurel	Routa Numbar,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:			examinetion an	e, death occurred at the ti d/or investigation, in my o					
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17	Willie M.	VEMBA	aar (non zod)	(-3po, - mil)					
State Registrar	31. Data filed (Month, Day, Year) MAY 1 6 2000	Serve 32. Registrat	's Signature	Sports					



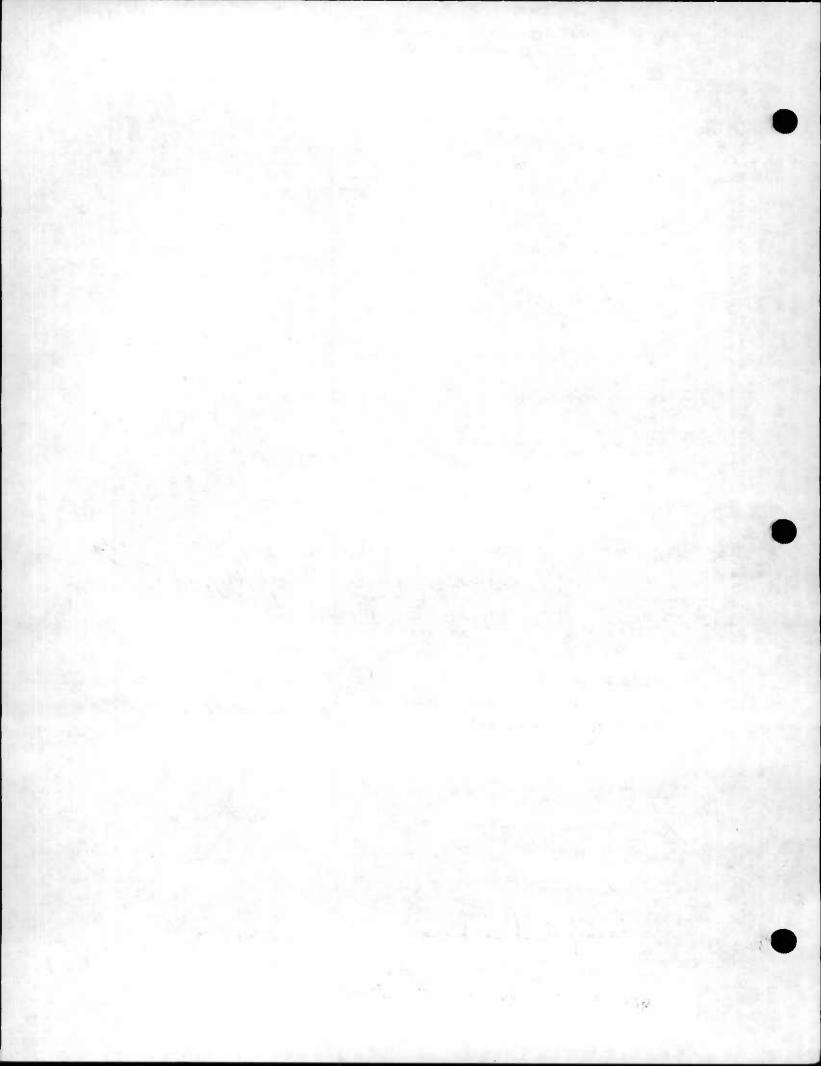
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#30 PER MD. G783 5-16-2000 JAB Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death 2000 Month **Physician** 11 Ella Mae May Webb 6:32 PM /Medical 4e Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3242 East Baltimore Street Baltimore If Under 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Yrs. Director 9, 1954West Virginia 211-44-8867 Usual Rasidance of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits "natural", or items 23s or 25s-f shor 1 Yes 2 No Directo Maryland Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the M Department of Health and Mental Psylone. Introduction 11 then 23a or 23a-f introduction; if then 72 it mexicos other than "returns", or items 23a or 23a-f any injury or other traumetic event, the Medical Examiner must be notified any injury or other traumetic event, the Medical Examiner must be notified. 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3242 East Baltimore Street 1st Floor 21224 USA Funeral 13. Wes Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decadant Ever in U.S. Armed Forcas? 14. Raca - American Indian, Black. Whita, atc. 1 ☐ Yes 2 No If Yas, Giva Yaar or Datas: 1 Nevar Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify Specify: ğ 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 7th Homemaker Domestic 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Jacob C. Netzer Eudora V. Malone 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Joseph Sauer / Friend 3242 East Baltimore St. Baltimore, Maryland 21224 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 5/15/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Greenmount Crematorium 21. Signature of Funaral Service Licensee 22. Name end Address of Fecility David J. Weber Funeral Homes, P.A. wen 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or haart failure. List only one cause on each line. **Physician** /Medical Immediate Causa (Final disaase or condition rasulting in death) Examiner Examiner The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): physician as the burial Box 68760, Physician/Medical Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 2□ No 3 □ Probably 4 □ Unknown by 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? page 2 should Completed peen has 1 Yas 2 No or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Chack only ona) No Hospital: Other: 4 Nursing Homa Certification: To 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 □Othar (Specify) this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death
10 Natural
2 Accident 28d. Dascribe how injury occurred 28b. Tima of injury 28c. tnjury at Work? within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funera 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 ☐ Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) filled in by 4 | Homicida To the Hospital Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a. Certifier (Check only 29b. Signature and title of certific 29c. Licensa number 29d. Date signed (Month. Dav. Year)

State Registrar 31. Data filed (Month, Day 3. Registraris Signature 2000

30. Name and eddrass of person who completed causa of greath (Item 23a) (Tyge, Print) LUHAR MIKESH onks



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

15680

	Certificate of Death								Reg. No.			
Physician /Medical	Lodema R. Wobbeking							2. Dete of Deeth Month Dey Yeer May 12 2000 10:0			3. Time of Deeth 10:00 F	
Examiner	4a Facility Ne <i>me (If not institution, give street and number)</i> 948 Armistead Way							Location of Deet more				
Funeral Director	5. Sociel Security Number 178-12-53	Sex 7. Age (In yrs. I		lest birthdey Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs	8. Date of Bi			lece (State or Foreign try) Sylvania		
land tand	Usuel Residence of Dece 10e. Stete 10b.	County		10c. City, Town or Location					10d. Inside City Limits			
death with the Maryland ms 23s or 28s-f show r must be notified at	Maryland 10e. Street and Number				Baltimore 10f Zip Code				1 ☐ Ya			
23e or all Dir	948 Armistead Way				21205				USA			
5 E	11. Meritel Stetus 12. Wes Decedent Ever in U Armed Forces 1 Never Merried 2 Merried 1 Yas 2 No 1 Yas 3 No 1 Yas 3 No				J,S. 13.	Wes Decedent of If Yes, specify Cut	Specify Yes or No to Rican, etc.)	Specify				
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n ne	(Specify only	rede completed)		(Give	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			Federal				
the Mo	Elemantary/Secondery		1-4or 5+)	Rece	Records Clerk			Governmen				
marked other imatic event, tr	17. Fether's Neme (First, Middle, Last) Frank Barber					18. Mother's Name (First, Middle, Maiden Surname) Jean Mellon						
or troum	19e. Informent's Name/Reletionship (Type, Print) Cherie Wilbur/Niece					19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8 Silverwood, Irvine, California 92604						
mportant: If them 27 is marked other than ny injury or other treumatic event, the Mode. To Be Comp	1 Pouls of Committee 2 Parameter Cast					lece of Disposition (Name of ametery, crametory or other placa) tro Crematory, Inc. 5/15/00 Baltimore, MD						
Department important: if any injury or once.	21. Signature of Superal Service Eigensee Thomas Gregor					Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228						
	23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiretory errest. Approximate											
sician edical miner	Immediete Ceusa (Final diseese or condition resulting in deeth)		ө	Great Dua to (TITAL or as a conse	ic lun carea 4 ronzus					Onsat end Death	
nding physician end use es the bunial-trensit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest b. Due to (or es e consequence of): C. Due to (or es a consequence of): d.											
	Pert II. Other significant of	onditions	contributing to death but not resulting in the u			nderlying cause givan in Part I.		23b. Did	23b. Did tobacco use contribute to the cause of c			
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To the Functed Directors After this certificate has completely filled in by the funeral director, page 2 Medical Certification; To Be Comp	Month, Day Year)					28b. Time of Injury M 28c. Injury et Work? 1 □ Yes 2 □ No 28d. Describe how Injury occurred 28d. Describe how Injury occurred 28d. Location (Streat and Number or Rural Route Number City or Town, Stete)					Il Route Number,	
he Funeral Dilately filled edical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the causa(s) and menner as steted. 20 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner stated.											
Med apple	end menner stated. 29b. Signeture end title of certifier						29c. License number			29d. Data signad (Month, Dey, Year)		
00	A. Purcel Staff physician				m	D19714			5/13/100			
(8)	30. Neme end address of MI CHAR C	PUP	sell, J	48VML	4114	Print)	nr Ave	BALTI	WAG ME	121	224	
State Registrar	31. Dete filed (Month, Dey	Year)	2000 I	Registrar's Sign	eture	& do	als		,			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month 10:15pm LLOYD A. WOOLRIDGE 2000 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center rosedale Baltimore 5. Sociel Security Number If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) Feb 12, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 F 217-01-3127 YES 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Tyes 2X No 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? 1000 Franklin Avenue #313 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes: 43-46 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) none floor mechanic construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Woolridge Margaret Jones 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Woolridge/spouse 1000 Franklin Avenue #313 Baltimore, MD 21221 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility State Anatomy Board 655 W. Baltimore Street turn of Europe Service Licensee | Director Baltimore, MD 21201 artt. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, ock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) cardiomyopathy Syerrs Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 1 Yes 2 No 3 Probably 4 Unknown acute Renal Failure 24a. Wes an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1 Yes 2 TNo 1 Yes 2 No

Physician /Medical Examiner

physician and is the buriel-transit

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signed by the

Be

edical Certification: To

The law requires that the deeth certificate be executed

Box 68760.

P.O. 1

Records,

Division of Vitai

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum

ool KingE, LLBYE

r 28a-f

Director

Funeral

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical by Completed

25. Wes case referred to medical

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 PNetural

2 Accident

3 Suicide

29a. Cartifier

4 ☐ Homicide

(Check only one)

29b. Signeture end title of certifier

har	(Specify)	
me		-
IITE	3	

Other: 4 Nursing Home 5 Residence 6 Ot

28d. Describe how injury occu

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

26. Place of Deeth (Check only one)

29c. License number

1 TYes 2 No

28c. Injury et Work?

29d. Date signed (Month, Dey, Year) may 8,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LCWONDA Summers 9000 Frankli DR. Lawauda Summers Franklin Square Drive Baltimore MD. 21287

State Registrar 31. Dete filed (Month, Day, Year) MAY 1 5 2000

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32. Registrar's Signeture

Hospital: 1 / Impatient 2 ER/Outpatient 3 DOA

28b. Time of

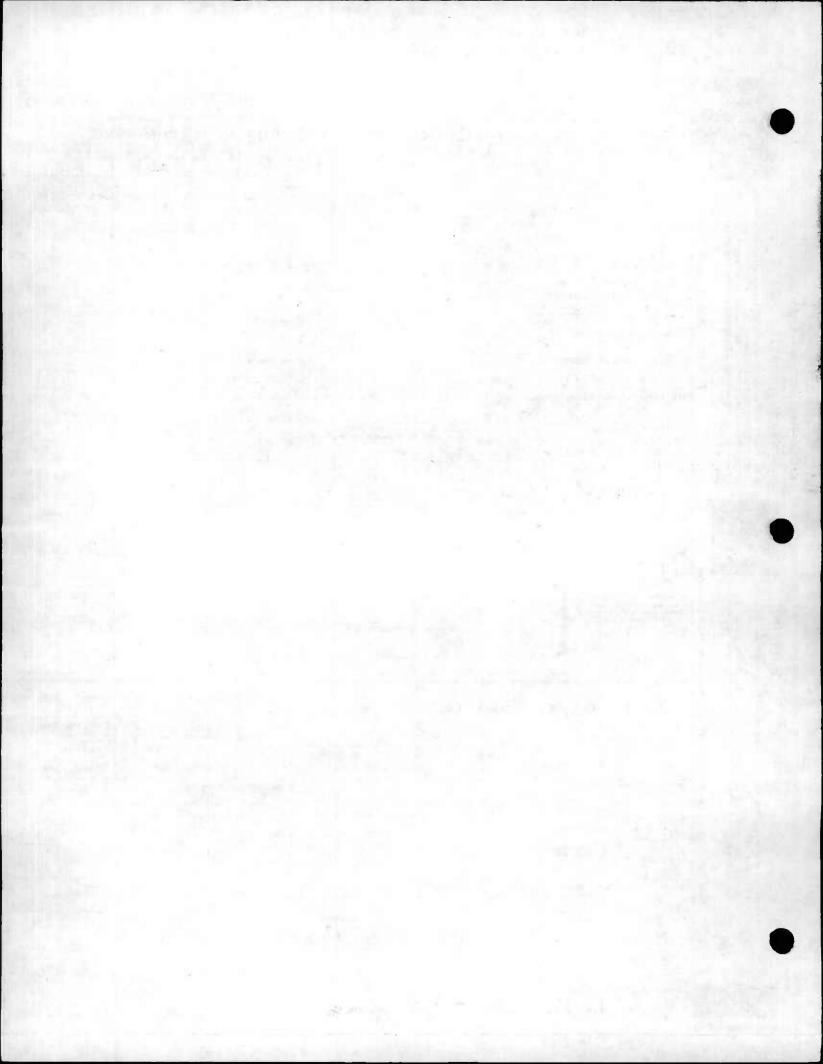
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

outs

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director; After this cartifica completely filled in by the funeral director, I



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 9:30 p.m Physician MILTON ZETLIN 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Battimore HOSPITAL of N/A If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1XX M 2□ F Vrs 214-01-9652 Director MAR. 31, 1910 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE OWINGS MILLS 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 HOUNDS HOLLOW COURT 21117 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Meniel Hygiens. Important: if Item 27 is marked other than "natural", or here 33s any flury or other traumatic event, the Medical Example must be once. 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 17 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: WHITE WWIT 3 k Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESMAN HOME FURNISHINGS 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) e SAMUEL ZETLIN BERTHA **HYMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 HOUNDS HOLLOW COURT - OWINGS MILLS, MD 21117 ELLEN JACHMAN / DAUGHTER Baitimore, 20b. Place of Disposition (Nama of cemetery, crematory or other plece) 20a. Method of Disposition Deta 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from State 4 □ Donation 5 □ Other (Specify) ARLINGTON CHIZUK AMUNO 5/15/00 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. irvice Licen (nun 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximeta Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finel disease or condition resulting in death) d days Examiner Due to for es a consequence of): Physician/Medical Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown erebral Vascular Accident Records. Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 D No 1 Yes 2 No 1 Yes certificate Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Nonpatient 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Mannegel Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fune 5 Pending investigation 1 Officeral 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated. Medicai 29a. Certifier (Check only one) iner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2000

Sinai 32. Registrar's Signature

me and address of person who completed cause of death (Item 23a), (Type, Print), Ita Garib, MD Sinai Hospita

TON

Hospitalot



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend item 23a,b,30 per phys. G783 5/16/00 yg Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar 8:35 AM **Physician** SOYCE Lrby April 2000 20 /Medical 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death Examiner Howard columbia HOWGRD County General HOSPITOI If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. Month, Day, Y March 1, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foraign Country) Year) 955 **Funeral** 1□ M 200 F 45 MD Yrs. 216-72-4021 Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Howard Columbia 1 ☐ Yas 2X No Directo Norms 23st or 28s-I 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6334 Cedar Lane 21044 Funeral USA 12. Was Dacedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas: Was Decadant of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, White, etc. ould be filed within 72 hours after Mental Hygiens. 1 X Navar Married 2 Married 8 Maryland 21215-0020 1 ☐ Yas 2 🖾 No Specify: Specify white p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) al Hygiena. Elemantary/Secondary (0-12) unk Collega (1-4or 5+) unk disabled none 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any injury or other traumatic ex If Health and Menta Item 27 is marked Charles E. Irby Margery R. Curtis 2 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Intormant's Neme/Ralationship (Type, Print) Margery Irby/mother 5950 Washington Blvd, Elkridge, MD 21227 altimore. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stete 4 X Donation 5 ☐ Othar (Specify) 21. Signature of Funa al Sarvice Licensaa Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one ceuse on each line. Approximata Intervel Between Onsat and Daath Physician /Nedical Immediata Causa (Final SEPSIS diseese or condition rasulting in deeth) Examinar Dua to (or as a consequanca of): Examiner piration PNEUMONIA The law requires that the deeth certificete be executed burial-transit Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disaasa or Injury that initieted avants rasulting in daath) Last ua to (or as a consequance of): and Box 68760, Sei Zure disorde Physician/Medical the Dua to (or as a consequenca of): 88 for use P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? signed by 1 □ Yee 2 X(No 3 Probably 4 Unknown þ Records, 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? RC complation of causa of daath? certificate hes 1 Yas 2 ONNo Sinusi 7 1 ☐ Yes 2 ☐ No of Vital or Attanding Physician: funeral director. 25. Was casa ratarred to medical axaminar? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 tnpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No After this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Panding Investigation a efter deeth.

I Diractor: Aff 1 Yas 2 No 6 ☐ Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Specify) filled in by datarmined 4 ☐ Homicide within 24 hours e To the Funeral C completely filled Hospital Tertifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a, Cartifian (Check only one) To the I within 2 To the F 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifier DS09 20,2000 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) JACOR CHERIAN Howard County General Hospital Columbia, Maryland

Registrar **DHMH 16 Rev 6/95**

State

31. Data filed (Month, Day, Year)

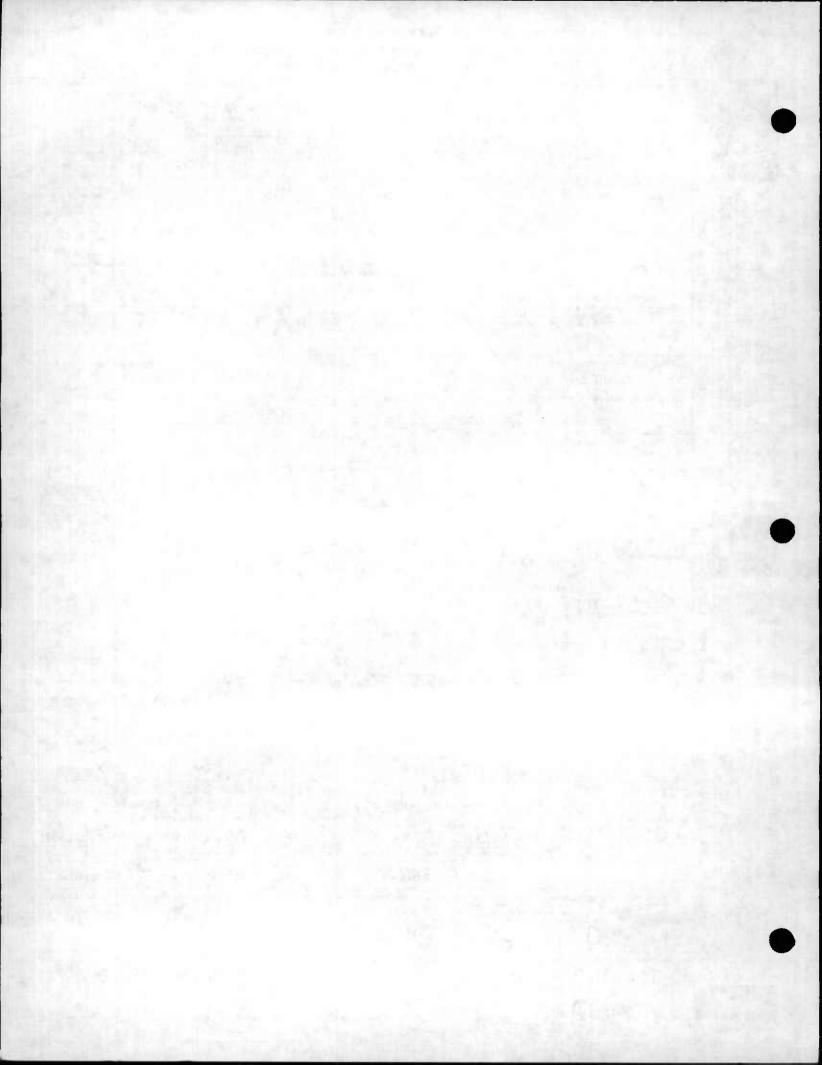
MAY 1 5 2000

32. Ragistrar's Signatura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 5 6 8 4

State of Maryland / Department of Health and Mental Hygiene

-2374-027	C	ertificate of Death	Reg. No.	
	Decedant's Nama (First, Middla, Last)		2. Data of Death	3. Tima of Death
Physician /Medical	TIMOTHY NEIL BRIERLEY		Month Day Yaar MAY 7, 2000	1545 PM
Examiner	4a Facility Name (If not institution, give street and numbar)	4b. City, Town, or L		
	MEADOWBROOK ROAD @ LONGGATE PARKW			
Funeral Director	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthd 17 Yrs	Months Davs Hours Min.		hplace (State or Foraign ountry) YLAND
anyland show id.st	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location		10d. Insida City Limits 1 ☐ Yes 2 ☐ No
vith the Man or 28s-f sh be notified.	MD HOWARD ELLICO		10- 08	XX
23a or ust be n	10e. Street and Number 10228 CLUBHOUSE COURT	101. Zip Code 21042	10g. Cifizan of What Co	ountry ?
0020 hours after des ural', or items al Examiner m d by Fune	11. Meritel Status 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas, S☐NO If Yas, Give \(\) X Yaar or Datas:	13. Was Decedant of Hispanic Origin? (Sf If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XX No Specify:	pecify Yas or No- Rican, atc.) 14. Race - Ama Black, Whit	a, atc.
1 21215-0 ed within 72 ho ygene. wer than 'naturn f, the Medical.	(Specify only highast grada complated) (G	ecedant's Usual Occupation iiva kind of work dona during most of work a. DO NOT use retired)	16b. Kind of Business/	Industry
212 Switt Spans The	Elamentary/Secondary (0-12) College (1-4or 5+) STU	DENT	EDUCATION	
Maryland 21215-0020 32 should be that within 72 hours at a should be that within 72 hours at he and Mental Hygano. The merical other than "natural", or traumatic event, the Medical Exam To Be Completed by F	17. Fathar's Nama (First, Middle, Last) NEIL BRIERLEY	18. Mother's Nem LISA FRO	a (First, Middle, Maiden Surname) OSÉLL	
ary man	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Addrass (Street and Number or Ru	ral Routa Number, City or Town, Stata, 2	Zip Coda)
. 6684	NEIL & LISA BRIERLEY/Parents 10	228 CLUBHOUSE COURT	F. ELLICOTT CITY. N	MARYLAND 210
Baltimore emit. Pages 1 t Separtment of He reportant if Hen iny Injury or oth since	1 Burial 2 N Cramation 3 Removal from State cemetary,	sposition (Nama of cramatory or other place) RE WASHINGTON CR.	Data 20c. Location - City or LAUREL, MAI	
Baltin Permit Pa Department Important any Injury	21. Signature of Funerai Sarvice Licensea	22. Name and Address of Facility W=5555 TWIN KNOLLS RI	tzke Funeral Home.	
	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximata Interval Batween
lecords, P.O. Box 68760, law requires that the death certificate be assecuted as been signed by the attending physician and be 2 should be detached for use as the burish-transit appleted by Physician/Medical Examiner	Immediata Causa (Final disaase or condition rasulting in daath) Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that infrieted evants rasulting in death) Last Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con Cause).	sequenca of):		
Box 6 eath certific attending p for use as	d			
cords, P.O. Box (vequires that the death certifueen signed by the attending should be detached for use a leted by Physician/M.	Part II. Other significant conditions contributing to death but not resulting in the	a undariying causa givan in Part I.	23b. Did tobacco use contribute	to the cause of death? robably 4 Unknown
The law requires the law requires the law seen signer page 2 should be completed by			performed?	Wera autopsy findings available prior to completion of causa of daath?
The law ate has page 2			1 Deyes 2□No	1 Yas 2□ No
/ita	25. Was casa rafarred to medical axaminar?	26. Place of Dea	th (Check only ona)	
Of Vital Physician: T this certificat ral director, p	Yas 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing H	oma 5□ Residence XXOthar (Spe	ocity) AT SCENE
ng Pt then the then the then the then the then the then the then the then the then the then the then the then the then the the then the then the then the then the then the then the then the then the then the then the the	27. Mannar of Death 1 □ Natural 5 □ Panding (Month, Day Year) 28b. Tim	ry Work?	28d. Dascribe how injury occurred	11
Attending at death. ctor: After by the fune liftcation	2) Accident Invastigation 5/7/00 3:3	5 PM 1 Yas 25 No	DRIVER IN MOTOR VEHIC	
Division of the or Attending P is a fear death. al Director: After led in by the funer. Certification:	detarmined 4 ☐ Homicide detarmined detarmined 28a. Piace of Injury - At home, ferm building, etc. (Specify)	, street, factory, office	281. Location (Straat and Number or A City or Town, State) MEAGUMS LOCKINE (MICHALLY, FILICH)	COX (LOAD AN)
Division of Vital Re To the Hospital or Attending Physician: The I- within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	and dua to the cause(s) and manner a	s stated.
To the within To the comp	29b. Signatura and titla of certifiar M. A.	29c. Licanse number OCME	29d. Data signed (Mon. MAY 8, 2	
6	30. Nama and address of person who completed cause of death (Itam 23e) (Ty JACK M. 117MS, M.D. 11	_{pe, Print)} 1 Penn Street, Balt	imore, Maryland 21	.201
State Registrar	31. Deta filad (Month, Day, Year) MAY 10 2000 32. Registrar's Signatura	Ann V		100



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth ^{Dey} 2000 Month 7:55 am 1, Janeda Burnham May 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Mariner Health of Greater Laurel Laurel Prince George If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys Months Hours 10 M 20 F 219-22-3012 72 APR. 21, 1928 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Prince George Laurel 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number 501 Main Street 20707 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Mental Status 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 XWidowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Factory Worker Maryland Cup Corp. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Ward Wiley Zelma (Unobtainable) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 10769 W. Crestview Lane, Laurel, Md. Dawn Keeter - daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 5/04/00 1 □ Buriel 2 □ Cremetion 3 □ Removal from Stete Mt. Olive Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Randallstown, MD 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 01050 7250 Washington Blvd., Elkridge, Md. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset end Death Immediate Cause (Fine) months disease or condition resulting in deeth) Due to (or es e consequence of) Due to (or es e consequence of)

Physician /Medical Examiner

that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

filed within 72 hours after

Hygiena.

pemit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event.

Saltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

Examiner physician and the burial-transit Physician/Medical þ Completed Be 10 To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certification:

certificate

After t

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Atuel phr. letion 24a. Wes en eutopsy performed?

24b. Were eutopsy findings eveilebie prior to completion of cause of death? 1 Yes 200 No 26. Place of Deeth (Check only one)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 XX 27 Menner of Deeth 1 Neturel 5 Pending Investigation 2 Accident

6 Could not be

25. Wes case referred to medical

31. Dete filed (Month, Dey, Year)

28a. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier rytam 29c. License number D28998 29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) SAINI MY PRITAM

9101 Cherry 5 ust 211

State Registrar

MAY 1 1 2000

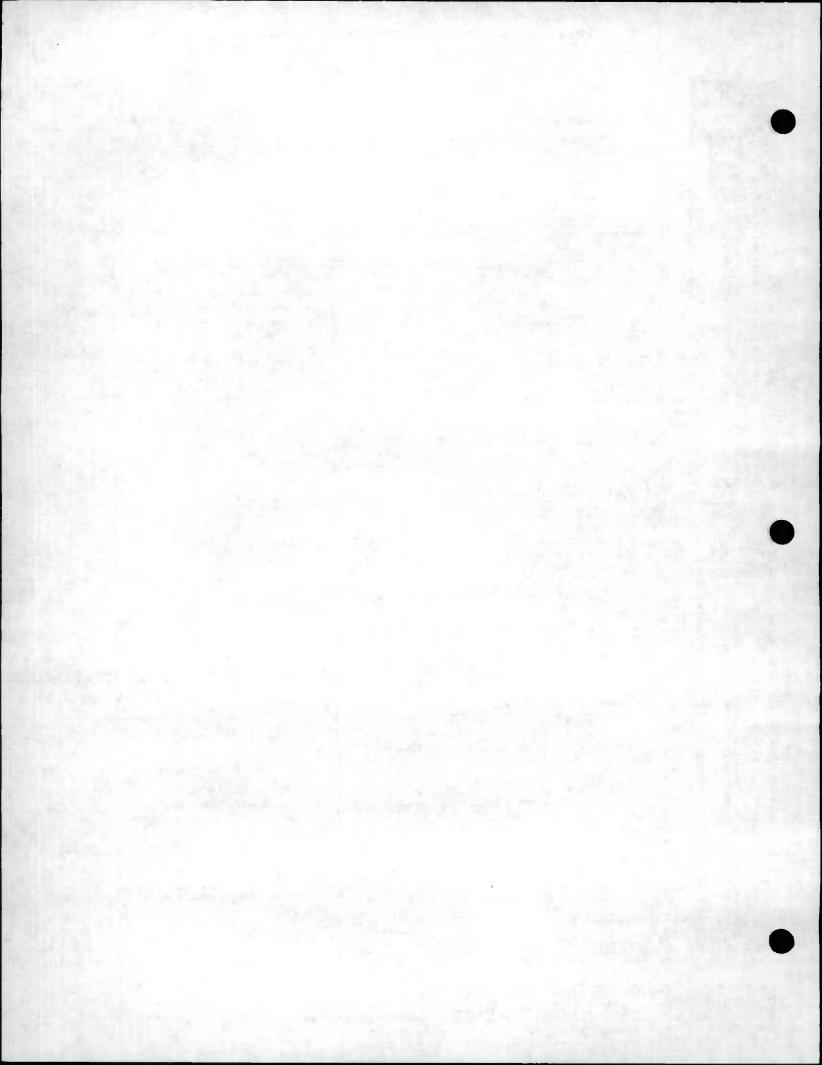
32. Registrer's Signeture

ORIGINAL

5

Medical

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death AMENDED ITEM #8 PER FH G784 6/13/2000 AH 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** Ruth S. Bohning 3:45 pm Mar 2000 /Medical 4e. Fscility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth G atousville

If Under 24 Hrs. 8. Dete of Birth
Hours Min. 8. (Month, Dey, Baltimore haylestown Care Center If Under 1 Yeer 75dr) 3 / 23 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Deys 1 M 2 X F Months 76 Director Mary Land 217-16-1218 Usuel Residence of Decedent with the Maryland permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mentel Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nothered at once. 10e. Stete 10c. City, Town or Location 10d. Inside City Limits MD Ellicott City Howard 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21043 U.S.A. 3962 Old Columbia Pike Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: P 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usuei Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Christine Denker George Irvin Nevaker 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) David Bohning 3962 Old Columbia Pike Ellicott City, Maryland21043 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Parial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Park 5-5-00 Elkridge, Maryland 21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility MO1050 Gary L. Kaufman F.H. Meadowridge Memorial Park 7250 Washington Boulevard Elkridge, Maryland2107\$ 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Final diseese or condition Phpumonia days Examiner Examiner been signed by the ettending physician and should be deteched for use as the buriel-transit Physician/Medical ģ

Completed Certification: To

Medica

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year)

Andres Salgzur

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

2000

711 Maiden

32. Registrer's Signeture

To the Hospital or Attending Physician: The lew require within 24 hours effer death.

To the Furneral Director. After this certificate hes been six completely filled in by the funeral director, page 2 should

Division of Vital

State

resulting in death)	Due to (or es a consequence of):						
_	b		78.7					
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or es a consequenca of):						
thet initiated events resulting in death) Last	Due to (c	r es e consequenca of):						
	d				i			
Pert II. Other significant conditions co	entributing to death but not res	ulting In the underlying ca	use given In Pert I.	23b. Did tobacco use co 1 ☐ Yes 2 ☐ No	ntribute to the cause of death?			
				24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 □ Yes 2 □ No			
25. Wes case referred to medical			28. Plece of De	eeth (Check only one)				
examiner? 1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DO	A Other: 4 Nursing	Home 5 Residence 6 Other (Specify)				
27. Menner of Deeth 1√0 Neturel 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	3c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red			
3 Suicide 6 Could not be 4 HomIcide determined	28e. Pleca of Injury - At h building, etc. (Specif	ome, ferm, street, fectory y)	office	28f. Location (Street end Numb City or Town, State)	per or Rurel Route Number,			
29a. Certifier 1 ☐ Certifying Phy cone) 1 ☐ Medicat Example 2 ☐ M	rsicien: To the best of my kno Iner: On the basis of examine and manner steted.	wledge, deeth occurred etion end/or Investigation,	t the time, dete end plea In my opinion, deeth occ	e, end due to the ceuse(s) end me curred at the time, date end piece,	enner es steted. end due to the ceuse(s)			

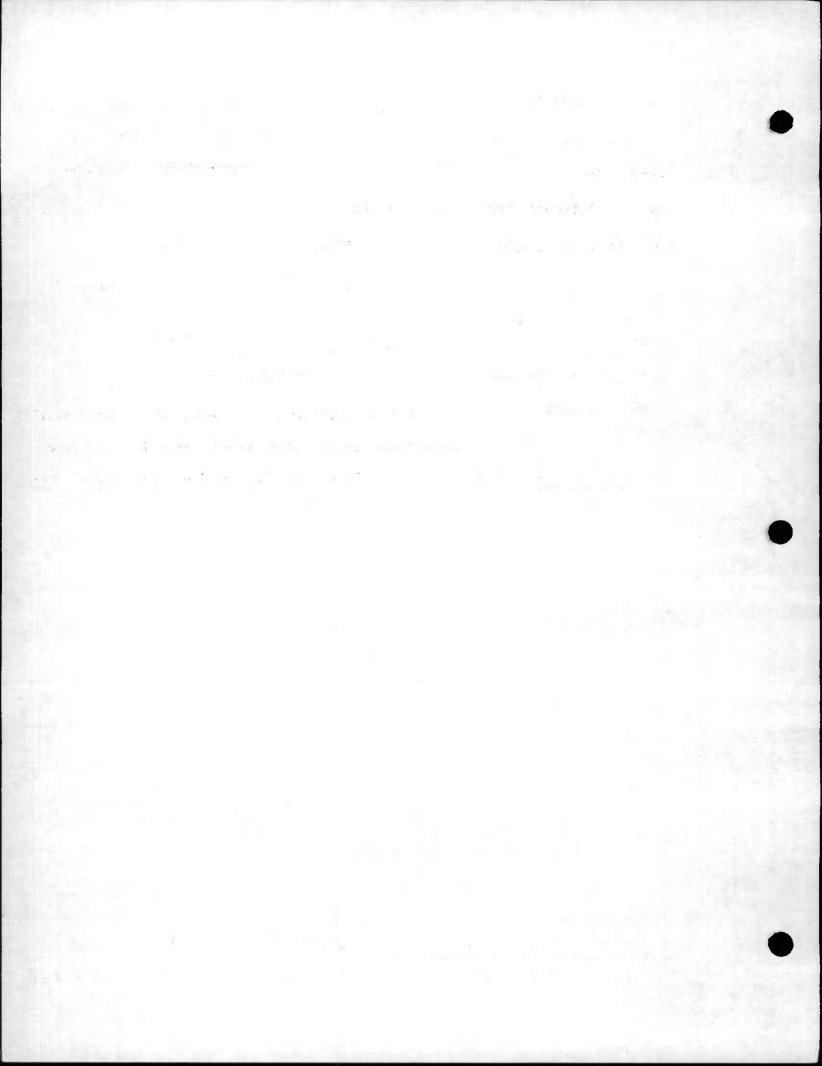
29c. License number

choice

29d. Dete signed (Month, Dey, Year)

Lane, Catopsville, MD, 21228

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Ba Taille 022000 -01/ 05 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Berlin Worcester Atlantic General | Wonths | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | 1/5/1925 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10€M 2□ F Vrs 150-12-1394 75 Director Usuel Residance of Decedant 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Worcester Berlin 1 X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code **USA** 4 Vine St. 21811 Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Giva Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White WWII 1 ☐ Yes 2 M No Specify: 3 XWidowed 4 □ Divorced 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working lifa. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Soft Drink Co. Truck Driver 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Be and 2 should be saith and Mental Grace Van Ness Alfred Henry Bataille 200 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce Elder/ Daughter 7823 Whaleyville RD Whaleyville, MD 21872 20b. Placa of Disposition (Name of cemetery, cramatory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 5/6/00 Berlin, MD Sunset Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Facility Burbage Funeral Home 21811 108 William St. Berlin, MD iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. art1. Enter the disease, or complication Approximate Interval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner nges five cartificeta be axecuted inding physician and use es the bunal-transit Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that initiated events resulting in death) Last Due to (or es a consequenca of) P.O. Box 68760. Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wera autopsy findings aveilable prior to completion of cause of daath? 24a. Was an autopsy performed? Completed is certificate has l director, page 2 : 1 Yas 2 No 1 ☐ Yes 2 ☐ No BatailleSR Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica Be 25. Was case raferred to medical 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 2 1 Yes 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 24 hours 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the vithin 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end titla of certifier D48130 2100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+1 Tettre Greenwood 9733 Healthway Dr. Berlin, MD

ones

32. Registrar's Signature Deneva

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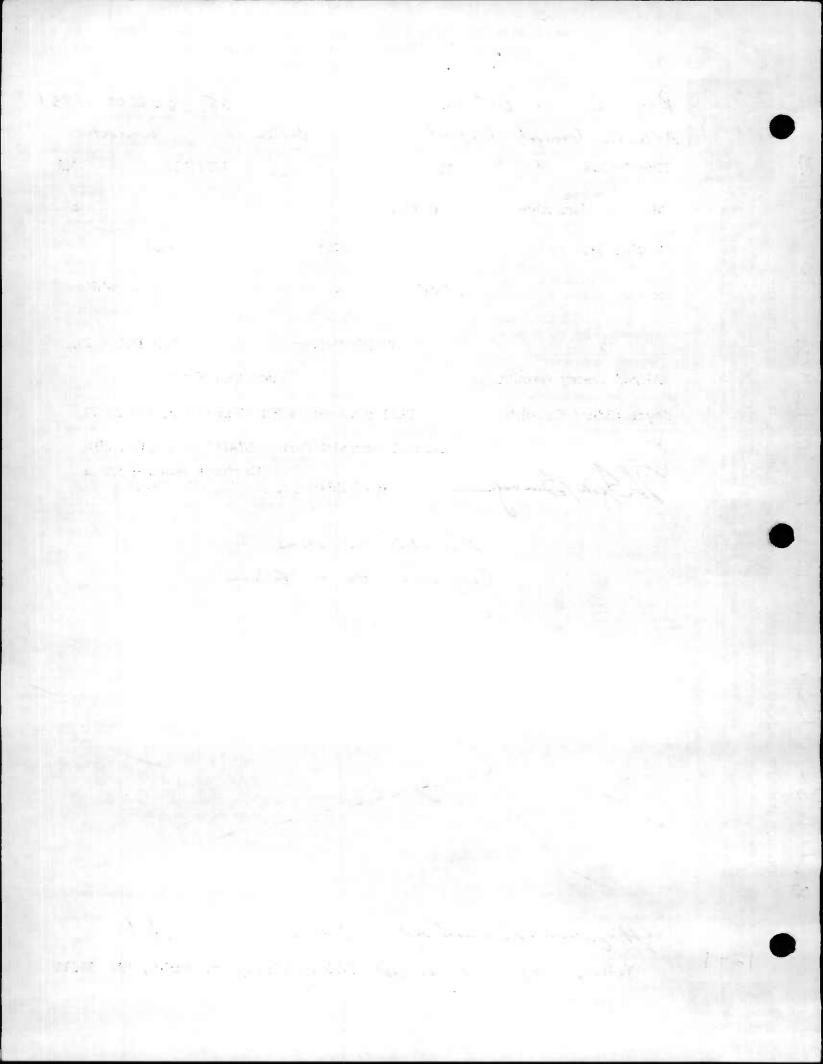
Registrar

31. Date filed (Month, Day, Yaar)

MAY 0 4 2000

DOB.

1364



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Benn Yeer Month Crumble 7:20 Am V10 0 30-2000 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hall Nursing Home Pocomoke WORCESTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 8. Date of Birth Month, Dey, Birthplace (State or Foreign Country) 115-22-4347 86 Months Deys Hours 1 M 2 F Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Locetion 10d. Inside City Limits Pocomoke 1 Yes 2 No wor ceston 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21851 Street U.S.A. 1006 Morket 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritei Status Race - American Indien, Bieck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 PNo Specify: Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) Coilege (1-4or 5+) Housewife Homemakin 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Albert osson eona Bryant 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Kath. P.O. Box 164 Melfa, VA 20b. Piece of Disposition (Name of cemetery, crematory or other piece) 20 munity Cemetery 22. Name and Address of Facility 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriai 2 □ Cremetion 3 □ Removei from State 5-6 -00 Cape Charles, VA. 4 ☐ Donetion 5 ☐ Other (Specify)

Physician /Medical Examiner

use as the bunal-transi and

for use as

ed by the e

page 2 certificate

funeral

daath. aftar daath Director:

To the Hospital or Atte within 24 hours aftar da:
To the Funeral Directo completely filled in by th

Physician

/Medical

Examiner

10a. Stete

MD

21. Signeture of Funerel Service Licensee

30. Name and didress of person who completed cause of deeth (Item 23e) (Type, Print)

MAY 0 3 2000

GREGORIO

BELLOSO, MD;

32. Registrer's Signeture

Funeral

Director

ral', or itema 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Depertment of Health and Mantal Hygiene. Important: If Itam 27 ia marked other than "natural", or Itama 23: any injury or other traumatic event, the Medical Examinations.

Maryland 21215-0020

Director

Funeral

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Completed

Be

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s been signed by t

or Attending Physician: The law requires thet the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	23e. Pen1. Enter the diseese, or com shock, or heer failure. List only	one ceuse on each line.	h. Do not enter the mode	of dying, such es cardie		Approximete Intervel Between Onset and Death
	Immediete Ceuse (Fine) diseese or condition resulting in death)	aletteriose	levotre (arkiova	scular Dis	ease 5 kgs
Examiner	Sequentieily list conditions,	Due to (d	or es e consequence of):			
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y Physician/Medical	Pert II. Other significant conditions of Dealectes	ontributing to death but not res	ulting in the underlying or	euse given in Pert I.	23b. Did tobacco use co 1 ☐ Yes 2 2 No	ntribute to the cause of death
Completed by	CVAZIC	A. Hem	iplegi	e .	24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?
	Vascular	Jement	ca. Tryp	enfercion	1 ☐ Yes 2 No	1 ☐ Yes 2 ₹ No
o Be	25. Wes cese referred to medical exeminer?	Hospitai:		Other	eth (Check only one)	
_	1 Yes 2 No 27. Manner of Death 1 Neturei 5 Pending 2 Accident Investigation			A 4 Nursing Bc. Injury et Work? 1 Yes 2 No	Home 5 Residence 6 Ott	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Piece of Injury - At he building, etc. (Specify	ome, ferm, street, fectory,	office	28f. Location (Street end Numb City or Town, Stete)	ber or Rurel Route Number,
edical	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medical Exem	ysician: To the best of my knowniner: On the besis of examined end menner stated.	wiedge, deeth occurred e tion end/or Investigetion,	t the time, dete end piece In my opinion, death occ	e, and due to the cause(s) end moured et the time, date end pieca,	enner as steted. and due to the ceuse(s)
ž	296. Signature and title of certifier	Bellen	29c. I	License number 295-05		d (Month, Dey, Yeer)

5302 CHINABERRY DR., SALISBURY, MD 21801

DHMH 16 Rev 6/95

State

Registrar

ME Wasters Paceninks Jour Market Street 311 51 Housewate 4 HEART TO STAND THE STAND Kiding Grant Elle all property seems by the contract of the Crayes Fineral Home carrier

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 15689

						Cer	tifica	te of	Death			Reg. No.		0.000
an 1	Decedent's Name (Fin	st, Middle, L	ast)								2. Date of Do Month	eath Day	Year	3. Time of Death
al _		GLENN	BAUMA								April	23, 20		3:45 P.M.
er 4	Facility Name (If not 1646 Cornf			umber)					4b. City, To		ocation of Deal		nty of Death	
5.	Social Security Number		Sex	7. Age /	In yrs. last birt	thday)	If Unde	r 1 Year			8. Date of Bi	th	9 Arui	
	214-40-364		1□M 21 F		56		Months	Days	Hours	Min.	Jul 25	y, Year)	Mary	nplace (State or Foreign untry) /land
-	sual Residence of Dec													
		. County		1	Oc. City, Town		ation							10d. Inside City Limits 1 ☐ Yes 2 🖺 No
	AD A Page 1 And Number	inne A	rundel		Pasade	ena	100.70	- 0-4-				10- 01	4140	
	1646 Cornf.	eld R	oad					p Code 122-				USA	or what Col	untry?
_	1, Marital Status	icia n	12 Was Day	cedent Ev	er in U.S.	13. W			tispanic Or	igin? (Sp	ecity Yes or No		ace - Amar	ican Indian,
	1 Never Married	2 Married	Armed F	2 No				ecify Cub			ecity Yes or No Rican, etc.)		lack, White	o, etc.
	3 ☐ Widowed 4 ☐	Divorced	If Yes, G Year or I	ove Dates:			⊔ Yes	2 🗀 No	Specify			Spa	nite	
	15. (Specify or	Decedent's E	ducation rade completed)	16a.	Decede (Give k	ent's Usi	al Occup ork done	pation during mos d)	st of work	ing	16b. Kind of		ndustry
	Elementary/Secondary	(0-12)	College	(1-4or 5+)	Ac				o) ve Ass			Creii	Cal	
	7. Father's Name (First,	Middle, Las	t)								e (First, Middle	, Maiden Sum	eme)	
	William	Joseph	h Morris	sett,	Jr.						thy Ma			
1	9a. Informent's Name/	Relationship	(Type, Print) (Spou	se) 19b.	Mailing	Addres	s (Street	and Numb	er or Rur	al Route Numb	er, City or Tov	vn, State, Z	ip Code)
	Mr. Ronald	М. Ва	umann, S	r.	16	546	Corr	nfiel	Ld Roa	ad, I	Pasaden	a, MD 2	21122	
20	Da. Method of Disposition 1 Burial 2 Cre		Removal from		20b. Place of cemeter	Dispos y, crem	ition (Ne	me of other pla	ce)		Date Apr 28	20c. Locatio		
	4 Donation 5			Jiale	Crest	La	wn M	emor	ial	- 1	2000	Marri	ottsv.	ille, MD
2	Signature of Funaral	Service Lice	11 .	11		22	Name a	nd Addre	ess of Facili	Y Ho	me & Ch	apel,	P.A.	
	pria	non	· Hais	1			P.O.	Box	195	Syk	esville	, MD		
2	3a. Pert1. Enter the dis shock, or heart feil	ease, or con ure. List only	nplications that	caused the	e death. Do n	ot ente	r the mo	de of dyin	ng, such es	cardiac	or respiretory e	rrest,		Approximete Interval Between
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d	nmediate Cause (Finel isease or condition esulting in death)		· HD	enoc	accin	om	120	W	nKn	own	Prim	arel	1	1/24008
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u	ause (Disease or injury eat initieted events esulting In death) Last	- 5	C	Du	a lo (or as a c	onsequ	ence of)	:					1	
,	outing in doubly cust	L											- !	
			0											
P	art II. Other significant	conditions	contributing to d	leath but r	not resulting in	the un	derlying	cause giv	ven in Part	1.	23b. Did	tobacco use	contribute	to the cause of death?
											10	Yes 2 N	3 □ Pr	obably 4 Unknown
												en autopsy	24b. V	Vera autopsy tindings
												ormed?		vallable prior to completion of cause of death?
											10	Yes 2 ☐ No		□Yas 2☐ No
25	5. Was case referred to	medicat							26. Plac	e of Deet	h (Check only			
	examiner? 1 ☐ Yas 2 ☐ No		Hospitel: 1	Inpatient	2□ER/Out	tpatient	3 D	OA Oth	or.	ursing Ho	X	idence 6 🗆 0	Other (Spec	city)
17	7. Menner of Death	Pending	28a. Dete (Mor	of Injury oth, Day Y		ime of		28c. Inju	ry at		28d. Describe	how injury occ	curred	
	2 Accident	investigation	on				Ми	1 🗆	Yes 2	No	U,File			
	3 ☐ Suicide 6 L 4 ☐ Hornicide	determined	286. Plac	e of Injury ling, etc. (- At home, fai Specify)	rm, stre	et, fecto	ry, office				Street end Nu wn, State)	mber or Ru	rel Route Number,
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29	b. Signature and fitte o	f certifier	1 1 1)	01		29	c. Licens	se number			29d. Date sig	ned (Month	n, Day, Year)
	> //n	holas	10 Kg	1001	differ	1 ser	1	XSC	560)		April	25	700
30). Nama and address o	person who	conhpleted cau	se of deat	h (Item 23a) (Type, P	Print) 2	700	304			INPLI	7	21044
	Nicholas	In!	10UTD	clar	XX 110	065	-/1	441	· Par	uten	· / Pka	Calu	wh	w MO
31	. Dale filed (Month, Da			Registrar's	Signature	1	4	1			1		7 7 7 9 7	
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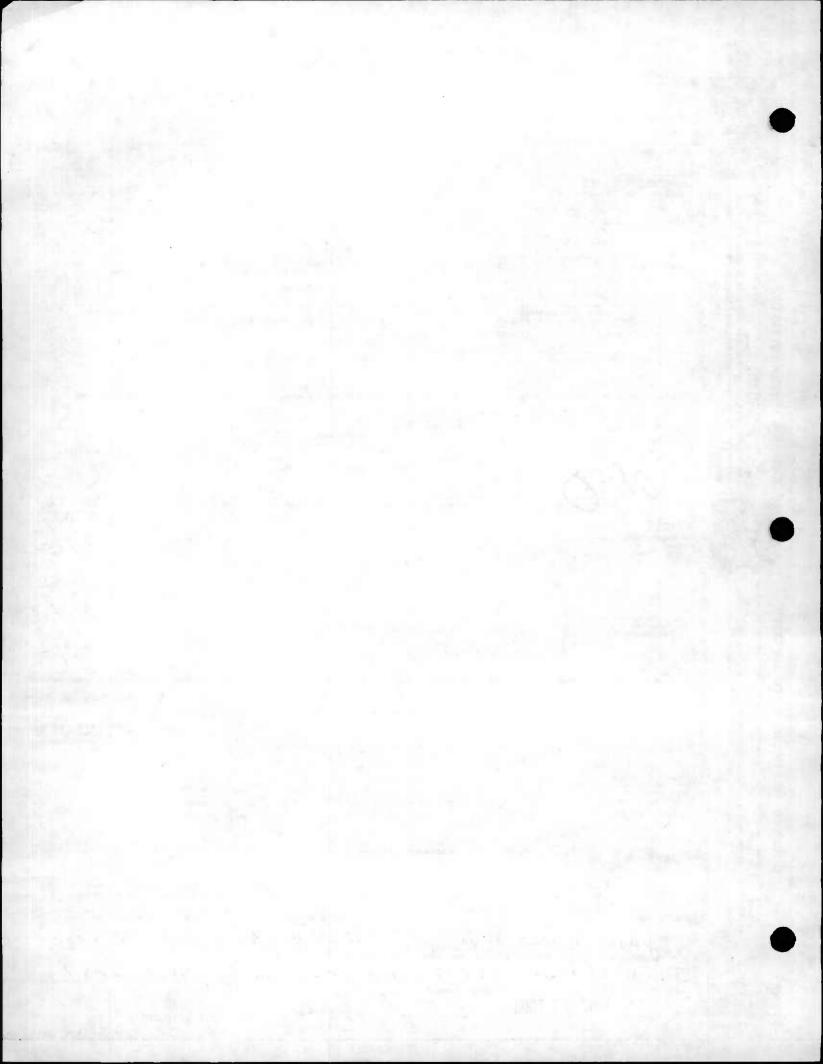
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_	Decedent's Name (First, Middentification)		- Indi yid		tment of I		2. Date of [Reg. No.	3. Time of Death
sician edical		EVAN LEF		LIZZARD			APRI	L 28, 2	000 5:47 AM
iner I	4a Facility Nama (If not institution CARROLL COU 5. Social Security Number	NTY GENER	RAL H	i. last birthday)	If Under 1 Year	WESTM:	INSTER Hrs. 8. Data of E. (Month, 1.5 / 2.2	CAR	ROLL 9. Birthplace (State or Foreig Country)
	214-28-1103 Usual Rasidance of Decedent 10a. Stata 10b. Count		68	Yrs.	lion		5/22	/1931	MARYLAND 10d. Inside City Limit
ctor	MD. CARR		1	ÉSTMINS					1 □ Yas 2 ☒N
Directo	10e. Street and Number 1347 BREHM R	ח			10f. Zip Code 2 1 1	5.7		10g. Citizen of USA.	What Country?
by Funeral	11. Marital Status 1 Nevar Married 2区 Ma 3 Widowed 4 Divorce	12. Was Deced Armed Ford Tied 1 X Yas 2	es? !□NoKOI	H Y		Hispanic Origin an, Mexican, P	? (Specify Yes or I uerto Rican, etc.)		ce - American Indian, ck, Whita, atc. y: WHITE
-	15. Decede (Specify only highe Elementery/Secondary (0-12) 8	nt's Education est grade completed) College (1-4		16a. Deceden (Give kin life. DO	n's Usual Occup d of work done NOT use retire CARPEN	during most of d)	working		usiness/Industry RUCTION
	17. Fathar's Nama (First, Middle	Last) ROSCOE BL	IZZAI	RD			Nama (First, Midd ONEIDA	le, Maiden Suman SYKES	ne)
	19a. Informant's Name/Ralation	ship (Type, Print)		19b. Mailing	Address (Street	t and Number o	r Rural Route Num	ber, City or Town	, State, Zip Code)
	PATSY BLIZZA 20a. Mathod of Disposition 1X Buriel 2 Cramation 4 Donetion 5 Other (3)	3 ☐Removal from St	20b.	1347 Place of Disposition cometery, cremate VIEW	on (Name of ory or other pla	ce)	Date	20c. Location	D. 21157 City or Town, Steta BURG, MD.
	21. Signetura of Funeral Sarvice	Licensee					LETCHER ., WEST	R FUNER	AL HOME
Examiner	tmmediata Causa (Final disaesa or condition rasulting in death)	s. Seps	VVT	or as a conseque					3 yru 24hr
	Sequentially list conditions, if any, leeding to immadiata cause. Entar Underlying Cause (Diseesa or Injury that initiated evants rasulting in death) Last	. M . De	I	or as a consequer					24hr
Fnysicianym	Part II. Other significant conditi	one contributing to deal	th but not re	sulting in the unde	ertying cause gi	ven in Part I.		d tobecco use co	ntribute to the cause of death
Completed by P								s an eutopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
EOS			3				10	Yes 2 No	1 ☐ Yas 2 ☐ No
on: To Be	25. Was casa referred to medica axaminar? 1 Yas 2 No 27. Mannar of Deeth 1 Natural 5 Pendi	Hospital: 1 1 Inp		ER/Outpatient 28b. Tima of Injury	3 DOA Ott	her: 4 Nursin	Death (Check only og Home 5 Re 28d. Describe		
Certification:		not be 28a. Place of	f Injury - At h , atc. <i>(Speci</i>	noma, farm, street,		Yes 2 No	28f. Location City or To	(Street and Numb own, State)	ber or Rural Route Number,
Medical	29e. Cartifiar (Check only one) 1 Certifyin 2 Medical	ng Physician: To the be Examiner: On the basi and manna	is of examina	owledge, death oc ation and/or invest	curred at the ti tigation, in my d	me, date and pl opinion, death o	ace, and due to the	e cause(s) end me e, date and place,	enner es stated. and due to the cause(s)
Me	29b. Signatura and titla of certifie				29c. Licens	se number		29d. Data signe	d (Month, Day, Year)
	John al Dr	iddleton W	no		12	544	3	04-	7 7- 7 000

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Dev Brooks 4:55am Chester May 5,2000 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 13705 Old Indian Head Road Brandywine Prince Georges o. December 7, 27 Mary Land Hours Min. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Days Months 1000 20 F Yrs. 578-48-1081 Usuel Residence of Decedent 10e. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Brandywine Maryland Prince Georges 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Coda 3705 Old Indian Head Rd 20613 U.S.A 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, Whita, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Navar Marriad 2 Married 1 Yes 2 No Specity: Specify. 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grede completed) 16e. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Federal Government 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surname) Bernard Brooks Vergie Gross Brooks 19a. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mildred A. Brooks/ Wife 13705 Old Indian Head Rd, Brandywine MD 20613 Ob. Piece of Disposition (Name of Deta 20c. Location - City or Town, Stata 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Mathod of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Ramovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory5/6/00 Alexandria VA 22. Nama and Addrass of Facility M00191 Adams Funeral Home P.A. Aquasco MD 20608 s thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, sa on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Final disease or condition resulting in deeth) LUNG CARCINOMA MONTHS METASTATIC Due to (or es e consequence of) Sequentielly list conditions, if any, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in deeth) Last Due to (or es e consequance of): Due to (or es a consequance of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Vee 2 No 3 Probably 4 Unknown 24b. Wera eutopsy findings available prior to 24e. Wes en eutopsy complation of ceuse of death? 1 Yes 2 No 1 Yes 2 No 25. Was casa rafarred to medical exeminer? 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide

physician and s the bunal-transit law requires that the death cartificate be axecuted P.O. Box 68760, attanding p for usa as signed by the a Records, been sig this cartificata has Tha Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica funeral 5 To the Hospital or within 24 hours aft To the Funeral Di complately filled in

Physician /Medical

Examiner

Examiner Physician/Medical by Completed Be 2 Certification:

Physician

/Medical

Examiner

Directo

Funerai

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Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, are Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

29a. Certifier (Check only one) 29b. Signature and title of coallies

28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et tha tima, data and place, and dua to the causa(s) and menner stated.

D 433 46

29d. Date signed (Month, Dey, Year)

30 Name and address of person who completed cause of death (Itam 23a) (Type, Print)

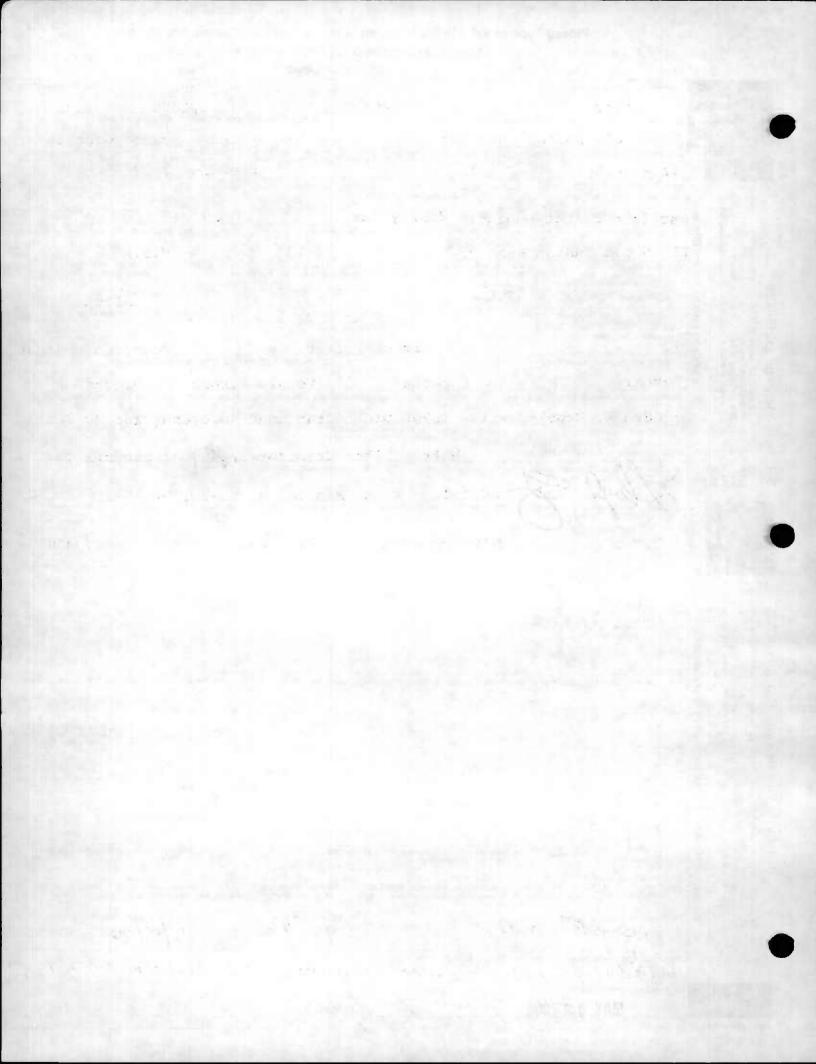
KITA GUPTA ND 8926 WOOD Y DRD ROAD #201, CLINTON ND 20735

State Registrar

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31. Data filed (Month, Day, Year)

32. Registrer's Signature



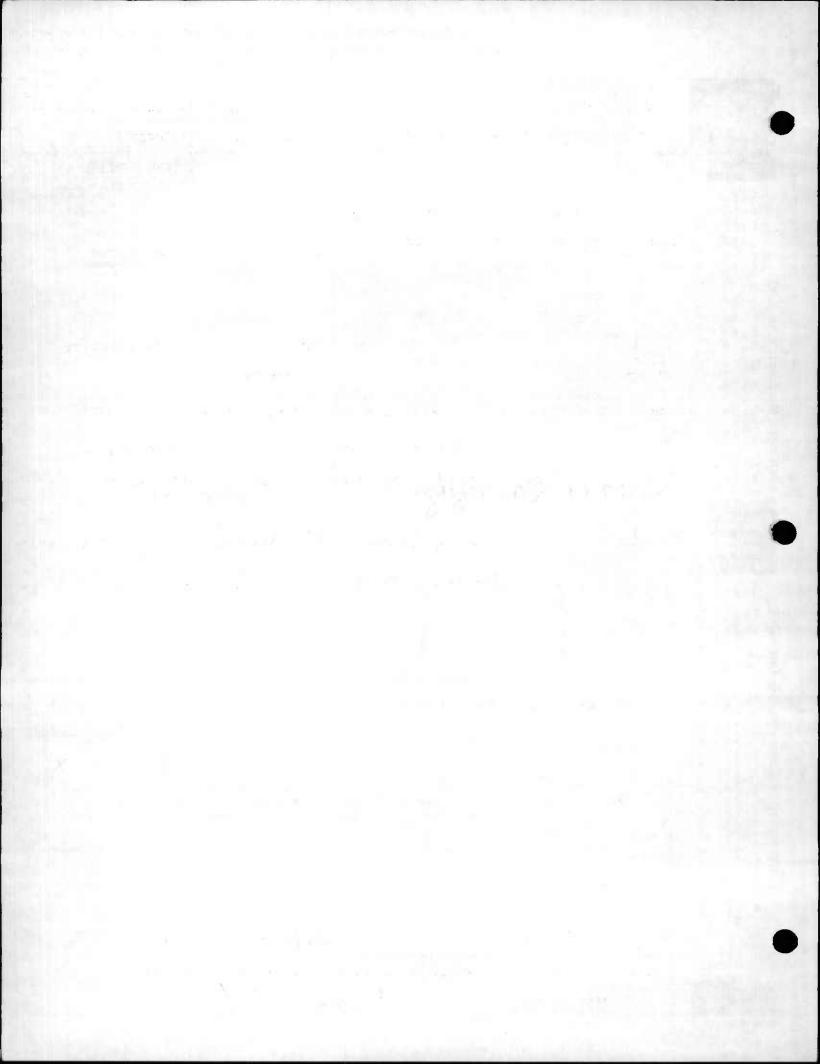
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** EUGENE BASS 29, 2000 April /Medical 12:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village Healthcare Center Westminster Hours Min. (Month, Day, Year)

June 22, 1915 If Under 1 Year Months Days 7. Age (In yrs. last birthday) **Funeral** 9. Birthplaca (State or Foraign 1 M 2□ F 332-09-5091 84 Director Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director XIX Yes 2 □ No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Lutheran Village Healthcare Luke Circle Carroll 200 St. items 23a Funeral 21158 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. pemit. Pages 1 end 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itel may injury or other traumatic event, the Mexical Evantine and. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Spacify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stone Mason Construction 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Albert H. Bass Clara Nat 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel Roth/daughter 438 S. Franklin Street, Hanover, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Buriai 2 Cremation 3 Remove from State Mary's Cemetery 5/3 4 ☐ Donetion 5 ☐ Other (Specify) Silver Run, MD 21. Signatura of Funaral Sarvice Licenses 22. Nama and Address of Facility Myers Funeral Home 91 Willis Street Westminster, MD 21157 23a. Part1. Enter the disease, or comple shock, or heert failure. List only on plications that caused the de one cause on each line. not antar tha mode of dying, such as cardiac or raspiratory arrest, Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Chronic ~2 month Examiner Due to (or es a consequence of): Physician/Medical Examiner hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Records, P.O. Box 68760, ettending physician for use es the buris that initiated events resulting in death) Last Due to (or as a consequence of) ed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Ninknown Completed by 24b. Were eutopsy findings eveilable prior to complation of causa of deeth? 24e. Wes en autopsy performed? 1 Yas of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spacify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral 28c. Injury et Work? 27. Manner of Deeth 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stata) 4 | Homicide Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 110 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maganbhai Pansuriya, M.D. 419-F Malcolm Drive, Westminster, MD 21157 31. Date filed (Month, Day, Yaar) 32. Registrar's Signatura State MAY 0 2 2000 gener Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Janice M. Banks

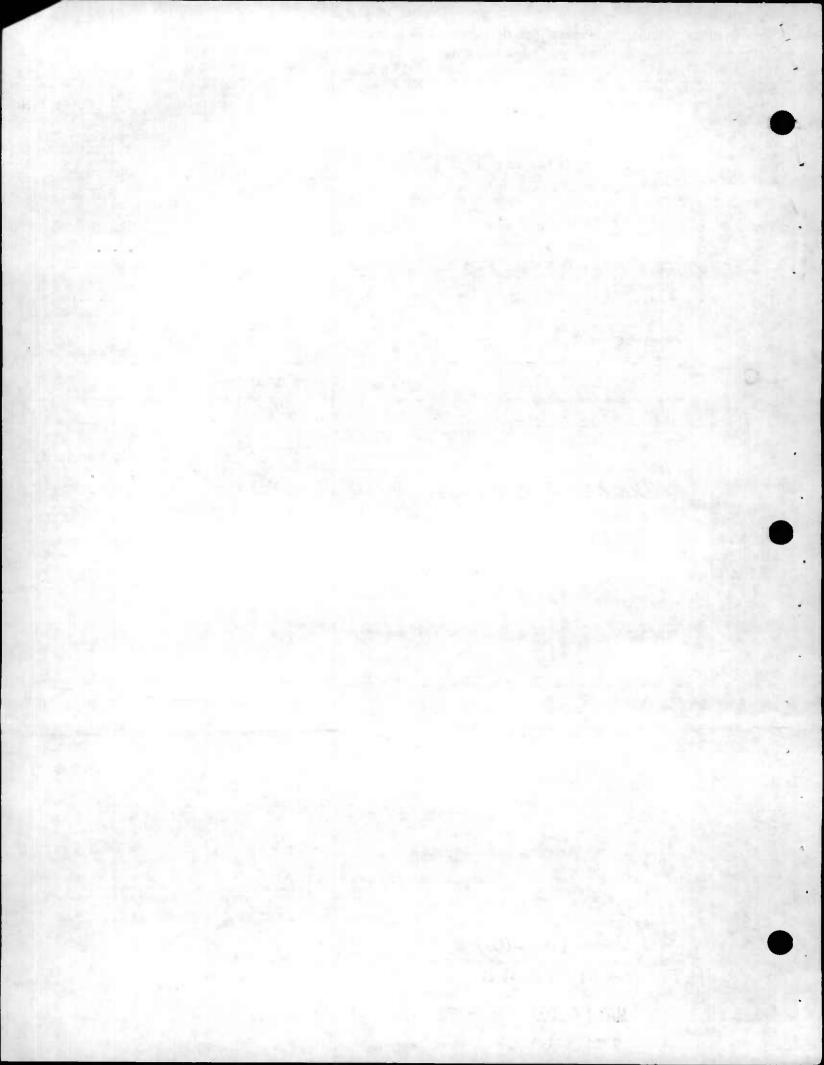
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Physician /Medical	1. Decedent'a	Name (First, Middle, I	ast)			danie,		2. Date	of Death	Day	Yeer	3. Time of Death
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Examiner	4a Facility Na	me (If not Institution, g	rive street end number)				4b. City, Town	, or Location of	Death	4c. County	of Deeth	
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neral ector	5. Social Secu 061-62-	-0279	Sex 7. Ag	e (In yrs. lest 41	birthday) Yrs.	If Under 1 Yee Months Days		Hrs. 8. Date Min. (Mon Marc	of Birth th, Dey, Ye h 1,	1959		aca <i>(State or Foreig</i> n try) York
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fed		15. Decedent's	Education	11	6a. Decede	nt's Usuel Occi	pation	f unding	161	. Kind of Bu	usiness/Ind	lustry
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DOCE.	21. Signature	of Funeral Service Lic	& Bola		663	Name end Add 33 Old .	ress of Facility Alexand	Lee Fu ria Fer	neral ry Ro	Home	, Inc	. MD 2073
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z should b									~	2 🗆 No	10	Yes 2 No
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rector, page 2 should	25. Was case examiner?		Hospitel: 1 ☐ Inpatie	int 2X ER/	/Outpatient	3□ DOA C	ther:	Death (Check	only one)	a 6 □Oth	er (Specif	y)
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend. #26, per Phy, TCHD, 2, 25, 00, b.b. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 12, 2000 Physician Month April Camper 9:37 AM Quynell Troy /Medical 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva street and number) 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours 18 M 2□ F Yrs **Director** June 6,1963 Maryland 216-88-9478 36 Usual Rasidence of Decedant I show 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 No Yas 2 □ No Director Maryland Dorchester Hurlock 10f. Zio Code 10e. Street and Number 10g. Citizen of What Country? P.O.Box 913 21643 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yas, Give Yaar or Datas: 8 1 Nevar Merried 2 Married 1 ☐ Yas 2 No Specify Specify: by 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry filed within Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 Worker Maryland Plastic Line Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 le marked othe eny linjury or other treumatic event potes. 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be 2 Camper Viola Johnson Charles Monroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) 176Gold Rush La., Prospect Hgts., Hurlock, Md. 21643 Gleneice Camper/sister 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition 1 ■ Burlal 2 Cremetion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Thompsontown Cemetery 4/15/2000 Thompsontown, Maryland 21, Signeture of Funerel Sarvice Lie 22. Nama and Addrass of Facility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset end Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical 5-10 years Examiner Dua to (or as a consequence of Examiner physicien and s the burlel-transit certificate be executed Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest Due to (or es e consequence of): 68760 Physician/Medical Dua to (or as a consequenca of) P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown tailue mode Records, þ very transplant 24b. Were autopsy findings eveilable prior to Completed 24e. Wes an autopsy low love a completion of cause of death? dealestes welliters with failed Lyret 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hypateusion 25. Was case rafarred to medical Transplant Division of Vital Attending Physician: Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 3 Thes 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Natural 5 Pending invastigation n 24 hours after death.

Ne Funeral Director: After pletely filled in by the fun 1 Yas 2 No 2 Accidant 6 Could not be determined 281. Location (Street and Number or Rurel Routa Number, City or Town, Steta) 3 Suicide 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida ŏ Hospital Certifying Physician: To the bast of my knowledga, daath occurred et the time, date end plece, and due to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et the time, date and pleca, end due to the cause(s) and mannar stated. edical 29a. Cartifier To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signature and tiple of certifier 29d. Data signed (Month, Day, Year) 29c. License number 27409 auvelle Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

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505A Dutchmen's Ln., EASTON, md. 21601

D. Rohan

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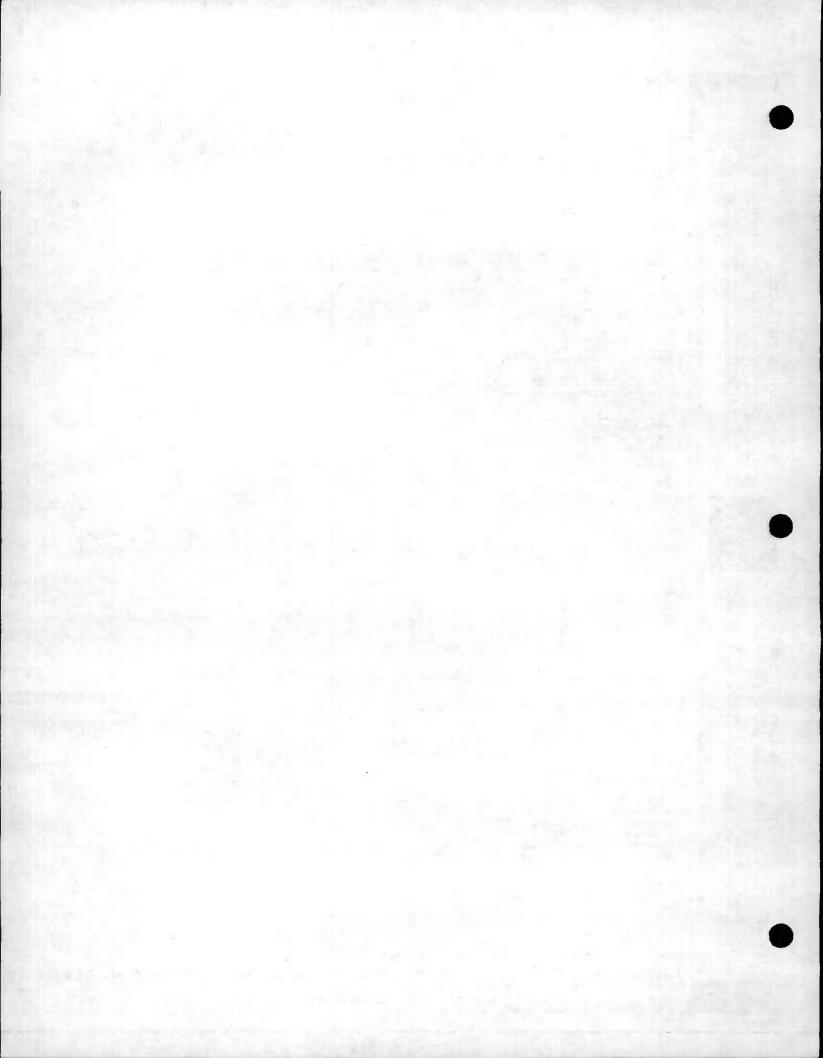
32. Registrar's Signature

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Lawrence

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31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Julia Ann Callaway April 30, 2000
cation of Deeth 4c. County of Death 12:50AM 4a Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 12536 Fleetway Dr., Ocean City Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Days 1 M 2 KF Vrs 215-38-1861 58 Dec. 6, 1941 Maryland Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits Md. Worcester Ocean City 1 No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12536 Fleetway Dr., 21842 US 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting Dept. Manager Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) **Nelson Topping** Mildred Powell 19a. tnforment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 146 Rupertus St., San Clemente, California 92672 of Disposition (Nome of Date 20c. Location - City or Town, State John J. Good, Jr. 20b. Ptace of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park May 4,2000 Berlin, Maryland Mary of Funeral Service Meensee 22. Name and Address of Facility
The Burbage Funeral Home Moorse 108 William St., Berlin, Md. 21811. the distance or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying, such as cardiac or respiratory arrest, and to do not enter the mode of dying. Approximate Interval Between Onset end Death tmmediate Cause (Final disease or condition resulting in death) CARCINOMA JOUN a ABDOM-NDL Due to (or as a consequence ot) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca ot): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 TYss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician/Medical Examiner

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Be Completed

Medical Certification: To

Physician

/Medical

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Director

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10a. State

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Saltimore, Maryland 21215-0020

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To the Funeral Director: Afte completely filled in by the fun

25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 5 Pending investigation 1 Naturat 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and menner es steted. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State Registrar

V 4 31. Date tiled (Month, Day, Year) MAY 0 1 2000

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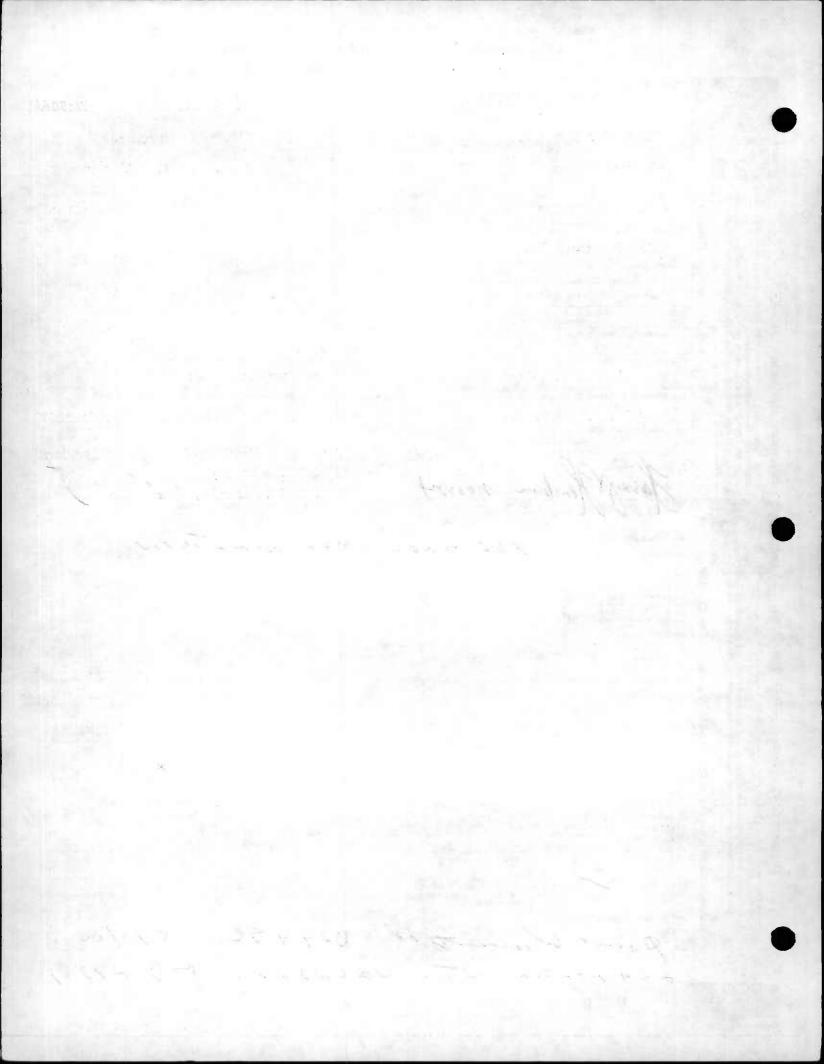
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

nRy

29d. Date signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Yeer Month **Physician** 600 CHARLES COULBOURNE **EMERSON** JR 2000 PYIL /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10XM 20 F Yrs. Director 219-34-3693 Virginia May 23,1914 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worcester Snow Hill 117 Yes 2 □ No Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 8 2 404 South Church Street 21863 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried 1 Yas 2 No If Yas, Give Yeer or Dates: 21215-0020 1 Yas 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 10 Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be f Department of Health and Mental 1 Important: If them 27 is marked of any injury or other traumatic eve Charles Emerson Coulbourne Sr. Zella Redden 19a. Informant's Name/Raletlonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace C. Coulbourne/Wife 404 South Church St., Snow Hill, MD 21863 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4/30/00 Stockton, MD Portersville Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Facility
Holloway Melson Funeral Home Professional Assoc 21. Signeture of Funas e Service Licensee m01129 103 Linden Ave., Pocomoke City, MD 21851 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failura. List only ona cause on each lina. Approximete Interval Batween Onsat and Deeth **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Examiner The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Physician/Medical Due to (or es e consequence of): USe as Box (P.0.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 (Inpatient

28a. Dale of Injury (Month, Day)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed?

1 Yes 1 Yas 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury el Work? 1 TYes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mennar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar stated.

(Check only one) 29b. Signature and fille of certifier 29c. License number

2 ER/Outpatient 3 DOA

28b. Time of

28a. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

23a) (Type, Print) 30. Name and address of pursers who to

State Registrar

á

ate has been signed page 2 should be de

certificate

After this

To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun.

funeral director,

Completed by

8

Medical Certification: To

25. Wes case referred to medical examiner?

31. Dete filed (Month, Day, Year)

5 Pending investigation

6 Could not be

APR 28

1 Yes 2 No

27. Manner of Death

1 DNeturel

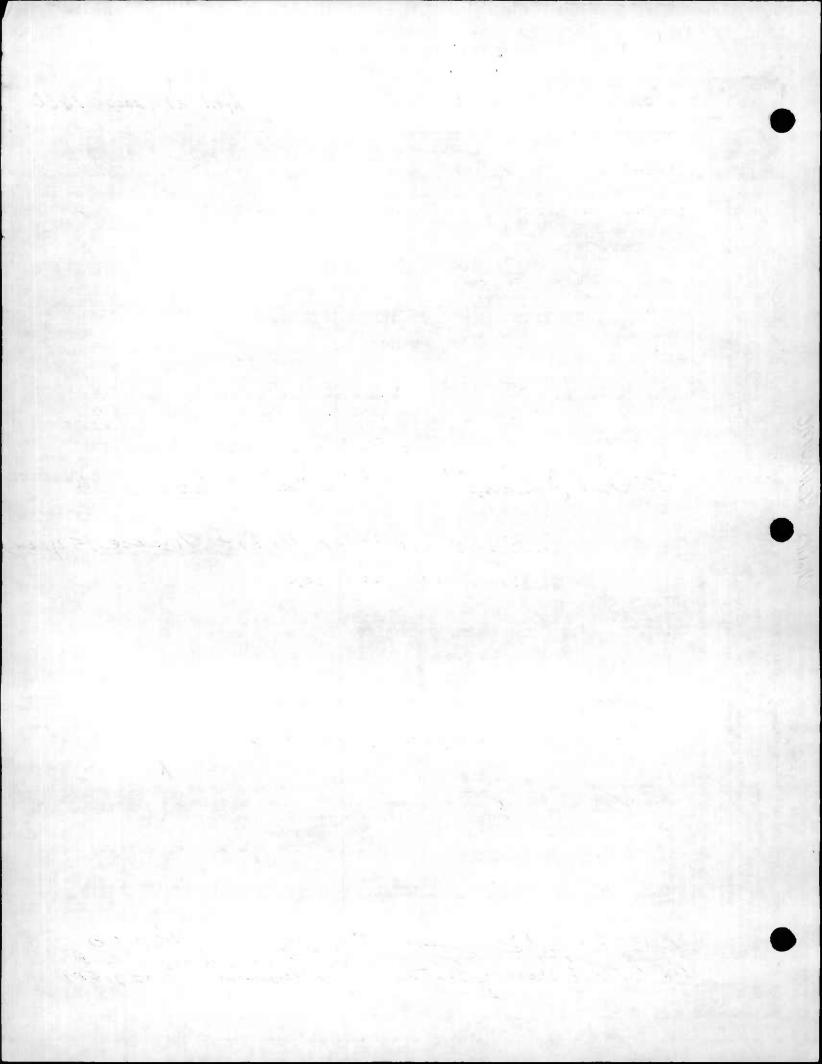
2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

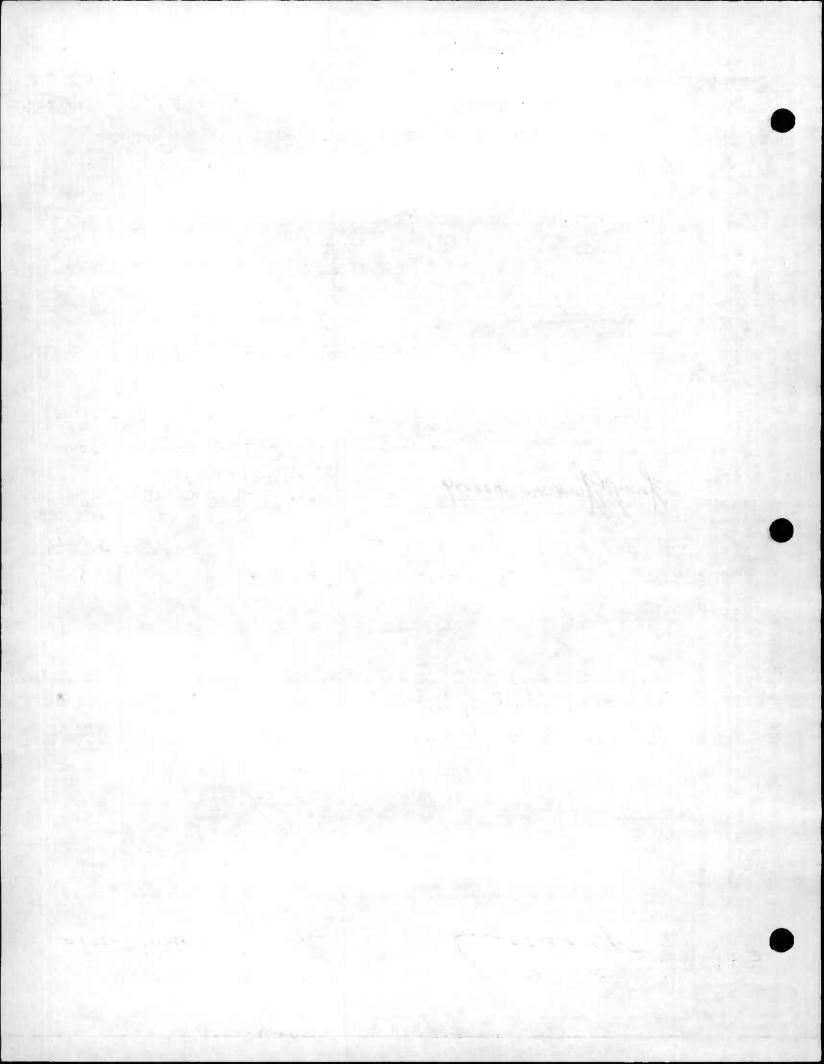
Records,

Division of Vital or Attending Physician:



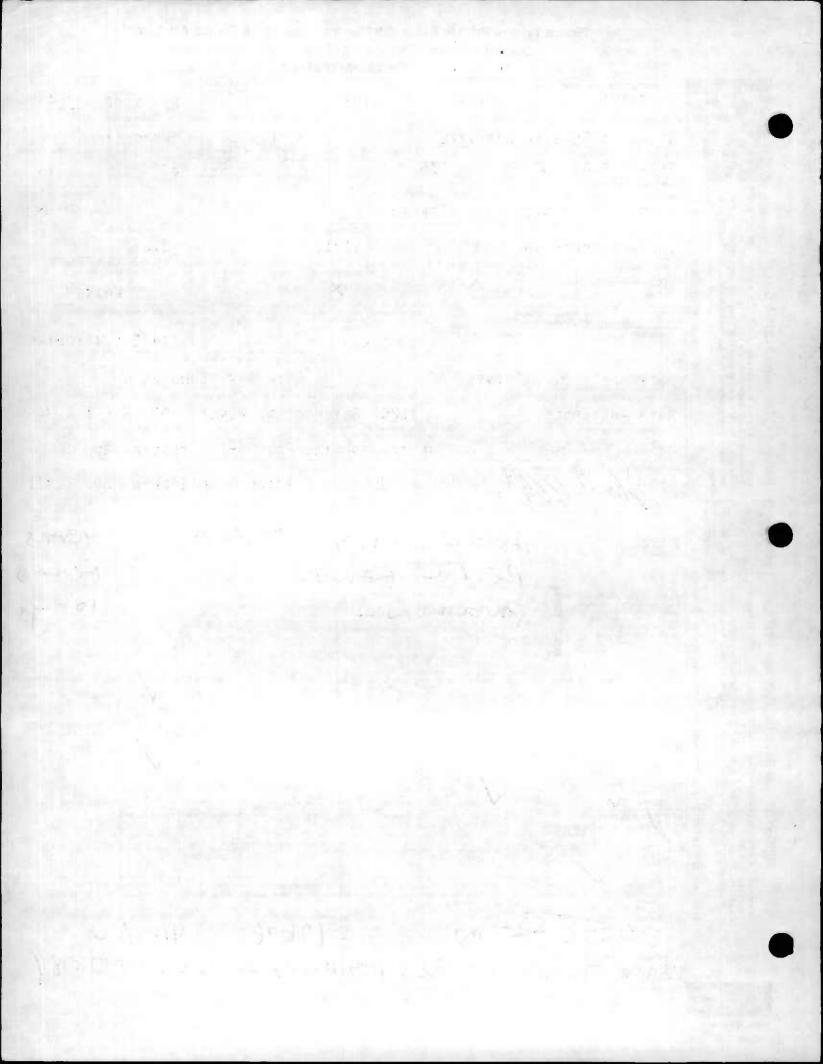
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 6 9 7

ainin.	Decedent's Na	me (First, Mid	idle, Last))					2. Date of Month	Death Day	Year	3. Time of Death
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miner	4a Facility Name								or Location of De		nty of Death	
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al or	5. Social Security 266-05-1 Usual Residence	8481	6. Sex	X JM 2□F	Age (In yrs. la	Yrs.	Months Days		Ain. (Month,	Day, Year) 18,1919		place (State or Foreigntry) V York
	10a. State	10b. Count	ty		10c. City.	Town or Loc	ation	107				10d. Inside City Limit
Director	Md.	Worce	ester	r	E	Berlin						1 □ Yes 2√2 N
į	10e. Street and N						10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	153 Wh	nite Ho					21811			US		
•		orried 2 Ma	arried	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	os? □₩WII	l It	Vas Decedent of I Yes, specify Cub		? (Specify Yes or uerto Rican, etc.)	8	lace - Ameri lack, Whita, city: Whi	, atc.
	(So	15. Decede	ent's Educ	cation e completed)		16a. Decede	ent's Usual Occu kind of work done OO NOT use retire	pation during most of	working	16b. Kind of	Businass/In	ndustry
	Elementary/Sec			College (1-4	or 5+)							
	17. Father's Name	e (First Middle	e (ast)	5+		Traffi	c Safety	Engin	eer Nam <i>e (First, Mid</i> k	Highw	ay De	epartment
		oyd S.		raill				13-7-		W	<i></i>	
	19a. Informant's I				SHEET ST	19b. Mailing	Address (Stree		e Webste		vn, State, Zij	p Code)
ĺ	1	J. Core							irt, Mt.			
	20a. Method of Di	isposition		417	1 00	ace of Dispos	sition (Name of natory or other pla		Date	20c. Locatio		
		2X☐ Cremation 5 ☐ Other (lemoval Irom Sta					y 5-2-00	Frankf	ord, D	Delaware
	21. Signature of F				1		Name and Addr					
	Jone	Miles	uders	on Mo	0284				neral Ho			
	1/1	4 (4)	or compli	ications that cou	sed the death.	Do not ente	or the mode of dy	ng, such as cer	Berlin, Midiac or respirator	arrest,	- 1	Approximate Interval Batween
	SHOUN, OF INC	bait spilure. Ex	St Only Or	ne cause on each	ii iirig.						1	Onset and Death
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	Immediata Causa disease or condit resulting in death	tion	a	5	1 0 C or	as a consequ	uence of):	1				honte
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cal Examiner	disease or condit resulting in death	lion i)	\$. G	Dua to (or	NIC as a consequ	uence of):	40)	7			shonte
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** THOMAS KEITH COINER 4 2000 0315 /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5-11-63 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months Days 1. M 2□ F Hours 36 Yrs. 213-88-5460 Director V۸ Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Marical Examination main be notlined at MD. 1 ☐ Yes No WORCESTER BERLIN Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 11204 GRIFFEN RD. U.S.A. permit. Pages 1 end 2 should be filed within 72 hours efter death v Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23. Funeral . Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedant of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AIR CONDITIONING OWNER 18. Mothar's Nama (First, Middla, Meiden Surnema) 17. Father's Nama (First, Middle, Last) Be D. COINER RUTH ANN BUMGARNER STEPHEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RUTH ANN DUDLEY 11204 GRIFFEN RD. BERLIN, MD. 21811 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cramation 3 □ Removal from State □ Donation 5 □ Other (Specify) ò SUNSET MEMORIAL PARK BERLIN, MD. 22. Name and Address of Facility 88 5460 ULLRICH FUNERAL HOME BERLIN, MD. 21811 23a. Part / Enter the disease, or complications thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrast, shock, or heert failure. List only one cause on each line. Approximate tnterval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner 3 The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last pue 2000 Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Due to (or as a consequence of) signed by the el 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy completion of cause of deeth? s certificate her director, page 2 1 TYes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 210 No Certification: To 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manuer of Death 1 Whatural 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No a Funeral Director; A Flore of File of Flore of 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nama and addrass of person who completed cause of death (Itam 23e) (Type, RSHOR 10VCA WAT 9733 Heglihman Dr Goelin MD21811 31. Date filed (Month, Dey, Year) 32. Aegistrar's Signature MAY 0 1 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Day Physician SALLY JANE CARRIER
4a Facility Nama (If not institution, give street and number) MAY 2000 06:39 AM Medical 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) April 17, 2000 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1□M 2 F 2 Days Min Yrs. N/A Director Usual Residence of Decedent with the Maryland 10b. County show 10a. Stata 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified as 1 ☐ Yas 2 No Director Parkton Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21120 18120 York Road Funeral death Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Was Decedent Evar in U,S. Armed Forces? 14 Bace - American Indian Black, White, etc. 1 Yas 2 No If Yas, Give Yaar or Datas: filed within 72 hours efter 1X Nevar Married 2 Married 1 Yas 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade complated) el Hygiene. Elamantary/Secondary (0-12) N/A College (1-4or 5+) N/A N/A permit. Peges 1 and 2 should be file Department of Health and Mentel Hy, Important: If item 27 is merked othe any injury or other traumetic avent, DDGS. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) James E. Carrier Ami W. Wist 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) James & Ami Carrier/Parents 18120 York Rd., Parkton, MD 21120 20b. Plece of Disposition (Nema of cometery, cremetery or other plece)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, Stata May 12, 1 Burial 2 □ Cramation 3 □ Removal from State Timonium, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Eumeral St ervice Lib 22. Nama and Addrass of Facility J.J. Hartenstein Mortuary, Inc. ari sus Dain 17349 24 Second St., New Freedom, PA 23a. Pan V Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, above, or high failure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Final EXTREME PREMATURITY 20 DAYS diseasa condition resulting in death) Examiner Due to (or as a consequence of) PNEUMONIA DAY Exami a the burial-tran Sequantially list conditions, if any, laeding to immadiata cause. Entar Underlying Cause (Disease or injury that initiated avents resulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, . CARDIDRESPIRATORY FAILURE Physician/Medical 94 Dua to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed has **D809** 2 1 ☐ Yes 2 No 1 Yes Be 25. Wes casa refarred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mennar of Death

1 Netural

2 Accident 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation Injury death 1 Yas 2 No Director: 6 Could not be detarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) filled in by or A 4 Homicida Hospital 24 hours a To the Hospital
within 24 hours a
To the Funeral C
completely tilled † Certifying Physician: To tha best of my knowledge, death occurred et tha time, data and place, end due to the cause(s) end menner es stated.

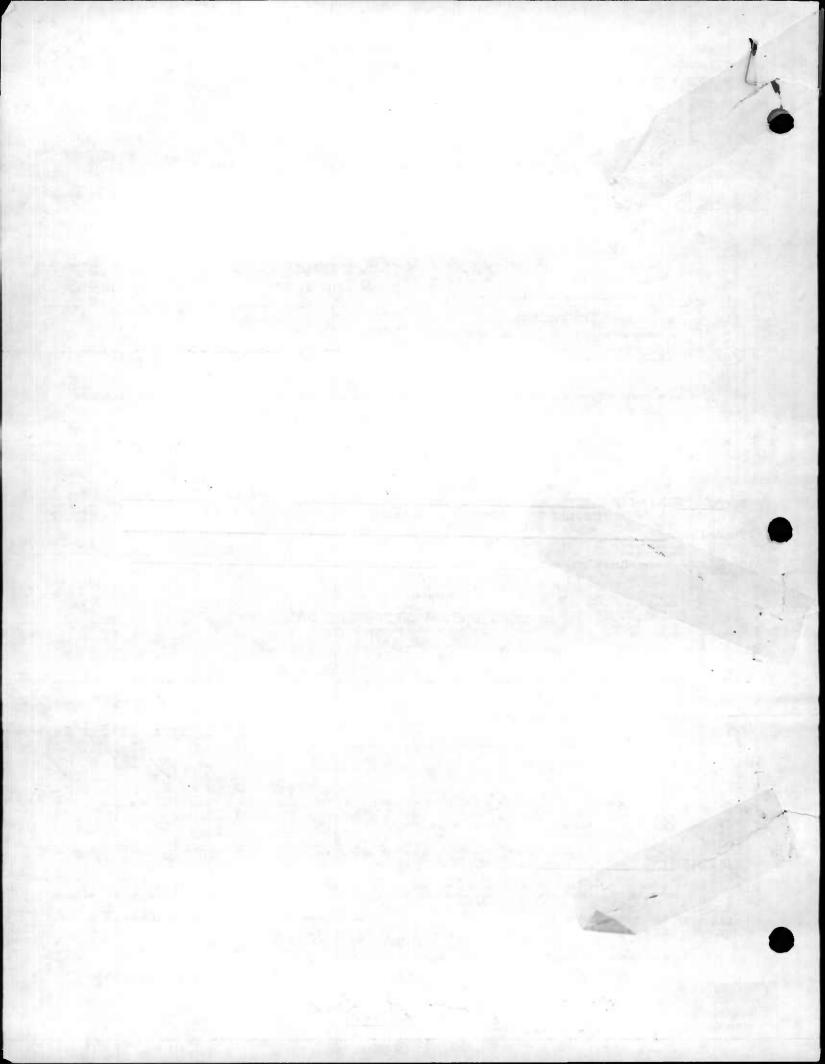
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier Medical (Check only 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian May 7, 2000 D0027352 Dennett 10 5-7-00 Name and address of person who complated causa of death (Item 23a) (Type, Print) MARILYN BENNETT. M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

ORIGINAL

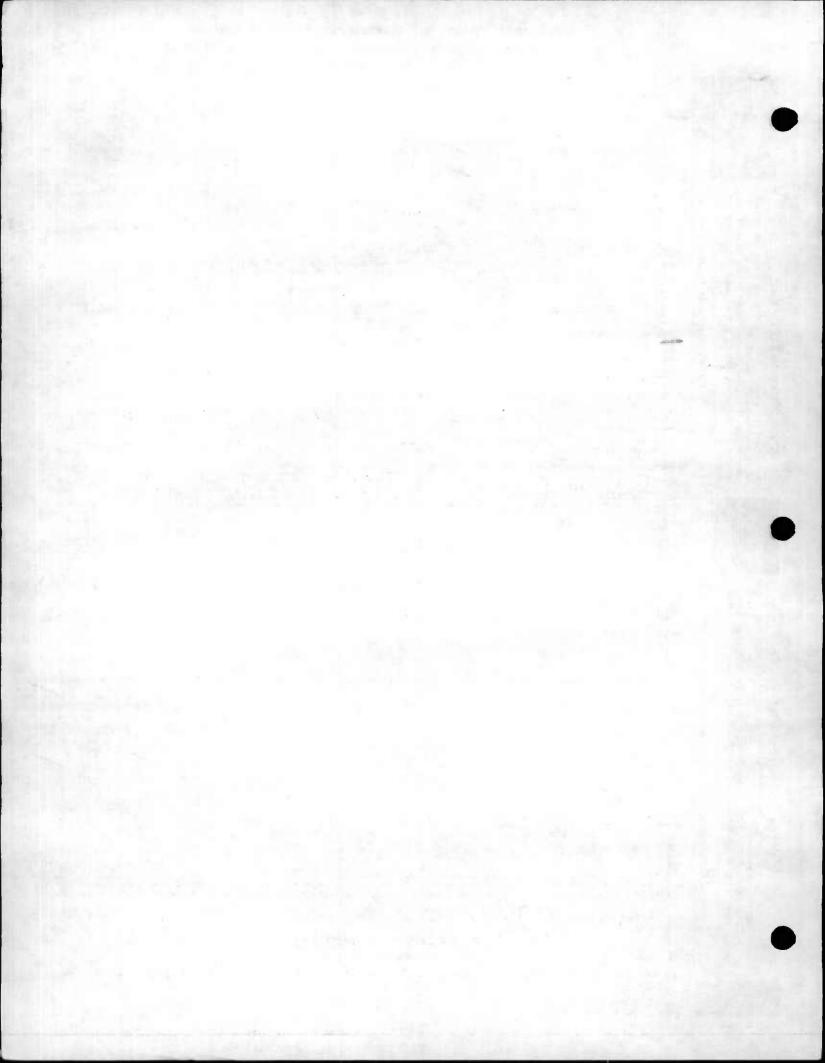
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Registrar

DHMH 16 Rev 6/95



		Cert	rificate of	Death	Re	g. No.	10.00	
1. Decedent's Name (First, Middle	e, Last)		2. Dete of Deeth		3. Time of Death	-		
CORA MAE ELLI	S							
4e Fecility Neme (If not institution	n, give street and number)			4b. City, Town, or L				
				Eastor	1	Tal	bot	
184-01-0643	40 H 40 -				8. Dete of Birth (Month, Day, 9-22-19	05	Birthplece (State or Foreign Country) NEWJERSEY	>
	10c Cit	v. Town or Loc	ation				10d Incide City Limite	
	ALDUI	EASTON			10	n Citizen of V	21	-
The second secon	S LANE			01	10	USA	viat country.	
	Armed Forces? ied 1 Yes 2 No	☐ Yes 2☐No 1 Yes Give 1☐ Yes 2☐No			ecify Yes or No- Rican, etc.)	Blac	ck, White, etc.	
15. Deceden	t's Education	16e. Decede	ent's Usuel Occu	upation a during most of work	ina 1	6b. Kind of Bu	usiness/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retin	9d)	9			
12	0	DENTA	L TECHN					
17. Father's Name (First, Middle, JOSEPH H. ELLIS	Last)			11			99)	
19a. Informant's Name/Relations	hip (Type, Print)	19b. Mailing	Address (Stree	et and Number or Rui	ral Route Number,	City or Town,	State, Zip Code)	Ī
SUSAN L. COLEMA	N/GRAND DAUGHTER	1131	5 OLD C	ORDOVA RD	, CORDOVA	,MD 21	625	
20a. Method of Disposition		Plece of Dispos	ition (Name of					
	3 Li Hemovel from Stete				4-24-00 5	STEVENS	VILLE, MD	
21. Signature of Funerel Service	Licensee							_
105:04 20	Ostowski						· · · · · · · · · · · · · · · · · · ·	
23a. Part1. Enter the diseese, or	complications thet caused the deet	h. Do not ente	the mode of dy	IRRISON ST	or respiratory arre	MD 216 st,	Approximate	-
shock, or heert failure. List	only one cause on each line.			0.00			Interval Between Onset and Death	
Immediate Cause (Finel	1. 1.0 101	Ni A /	+ 115	-115-10	11) A > C.C.	
resulting in deeth)	a MYOCANA	21/4	+10+	MITCHIO	<i>N</i>		MINGFES	,
	1 + 115 1 45-	or as a consequ	ence or):	0000000		Accor 4		
Conventinilly lies and distance	b. HIMEROSC	LEKOTI	C C 14	KUIOVAS	CYLAN	DISEAS	y y FARS	
if eny, leading to immediate ceuse. Enter Underlying			onos orj.				5 11S	
	0.		ence of):				YENNO	_
resulting in death) Lest	2001010	. 50 5 55,15545	0.100 017.					
	d							-
Pert II. Other significant condition	ons contributing to death but not res	ulting In the und	derlying ceuse g	iven in Part I.	23b. Did tob	acco use co	ntribute to the cause of death	?
			1 Yes 2 No 3 Probably 4					
					24a. Wes en	eutopsy ed?	24b. Were eutopsy findings available prior to	
		-	_				completion of cause of death?	
					1□ Ye	s 2 ENO	1 ☐ Yes 2 ☐ No	
25. Wes case referred to medical				26 Place of Pee				-
examiner?	Hospital:	EB/Outpatient	3 DOA 0	ther:			er (Snecity)	_
27. Menner of Deeth		28b. Time of						_
		Injury						
3 Suicide 6 Could	not be 28e. Plece of Injury - At he	ome, farm, stre	et, fectory, office	9			per or Rural Route Number,	-
4 Homicide					City or Town,	State)		
	and oftenner statets.			na number	26	d Plata sinna	d March Proc Mond	_
one)			20c Lione					
	15/1/1/		29c Licen	tae number	- 64	7	d (Month, Day, Year)	
one)	15 MW/ ma	IKAS	29c Licen	8241	24	4/22	O O	
29b. Signature and title of certifie 30. Name and address of person	who completed cause of death (Item	1/4/1/8 n 23a) (Type, P	+140	8241		4/22	1	
29b. Signature and title of certifie 30. Name and address of person DANIEL E. Y	who completed cause of death (Item	1418 n 23a) (Type, P	+140	8241		4/22	1	
29b. Signature and title of certifie 30. Name and address of person	who completed cause of death (Item MAKAS, DO 508-3 32. Registrer's Signa	14AS n 23a) (Type, P E DLEW) sture 4	+140	8241		4/22	1	
	CORA MAE ELLI 4e Fecility Neme (If not institution Genesis Elde 5. Social Security Number 184-01-0643 Usuel Residence of Decedent 10a. Stete 10b. County MD T 10e. Street and Number 610 DUTCHMAN 11. Menitel Stetus 1 Never Married 2 Menitary Secondary (0-12) 15. Decedent (Specify only higher Elementary/Secondary (0-12) 17. Father's Name (First, Middle, JOSEPH H. ELLIS 19a. Informant's Name/Relations SUSAN L. COLEMA 20a. Method of Disposition 1 Burial 2 December (Secondary (0-12)) 21. Signature of Funerel Service 10520 Menitary 22a. Part 1. Enter the disease, or shock, or heert failure. List Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet intitled events. Enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease or injury thet intitled events enter Underlying Cause (Disease enter ent	S. Social Security Number 184-01-0643 1	1. Decedent's Name (First, Middle, Last) CORA MAE ELLIS 4e Facility Name (If not institution, give street and number) Genesis ElderCare - The Pines 5. Social Security Number 184-01-0643	1. Decedent's Name (First, Middle, Last) CORA MAE ELLIS 46 Feclity Neme (If not institution, give street and number) Genesis ElderCare - The Pines 5. Social Security Number 6. Sex 184-01-0643 1	CORA MAE ELLIS 4e. Fecility Name (if not institution, give street and number) 4e. Cay, Town, or Location 5. Social Security Number 6. Sex 184-01-0643 1 M 2/F 7. Age (in yrs. last brindley) 1 Under 17 ear 1 Under 24 Hrs. 1 Under 17 ear 1. Decodent's Name (Pinz, Michdie, Leat) CORA MAE ELLIS	Decodor's Nume (Fins. Middle, Late) CORA MAE ELLIS 4. Featily Nume (print institution, pive street and number) Genesis ElderCare - The Pines 5. Social Security Number 6. Seet 10. Corpolation 6. Seet 10. Age (in yet) 10. Seet of Depth Institution (in the Institution of Depth Institution of Depth Institution (in the Institution of Depth	Deceder's Name (First Missis, Lari) 2.0 as of Deam Models 2.0 as of Deam	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Rebecca S. Garner May 8, 2000 12:15 am /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Catonsville Commons Catonsville Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys 1□ M 2♥ F Director 78 214-14-1893 Maryland Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examples must must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Ellicott City Howard 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 3320 St. John's Lane 21042 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Ernest R. Shipley 2 Edna Nitzel 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Roland Phoebus Garner/Husband 3320 St. John's Lane Ellicott City, MD. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 10 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 2000 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park Cemetery Baltimore, Maryland 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerel Service Licenses 101044 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Myo coolin 1 + who den /Medical Immediate Ceuse (Final disease or condition resulting in deeth) 150 Examiner Due to (or es e consequence of): Examiner attending physician end for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): P.O. Box 68760. Physician/Medical thet initieted events resulting In deeth) Last Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uee contribute to the cause of death? Strist tim. lasta 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy findings evelleble prior to completion of ceuse 24a. Wes en eutopsy page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes a No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 HomicIde **Excertifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer) D34951 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Catrollero 21214 455 hedrik Klonke 100 ED / Kample 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

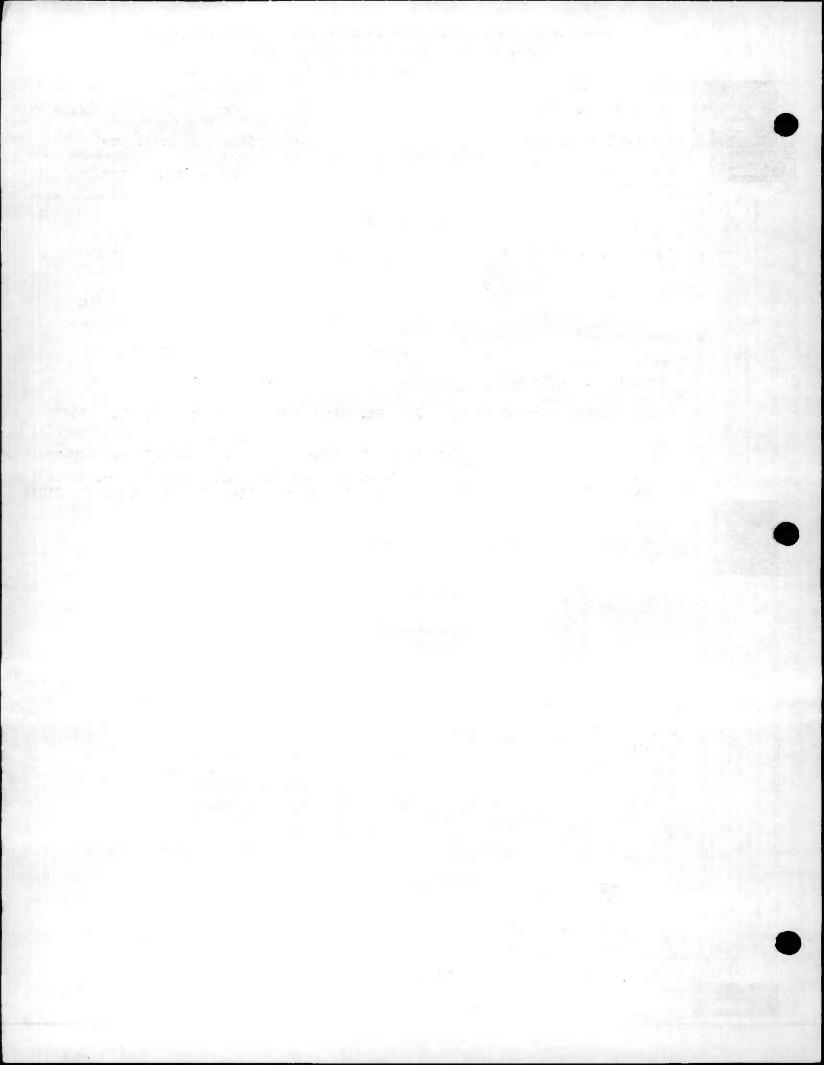
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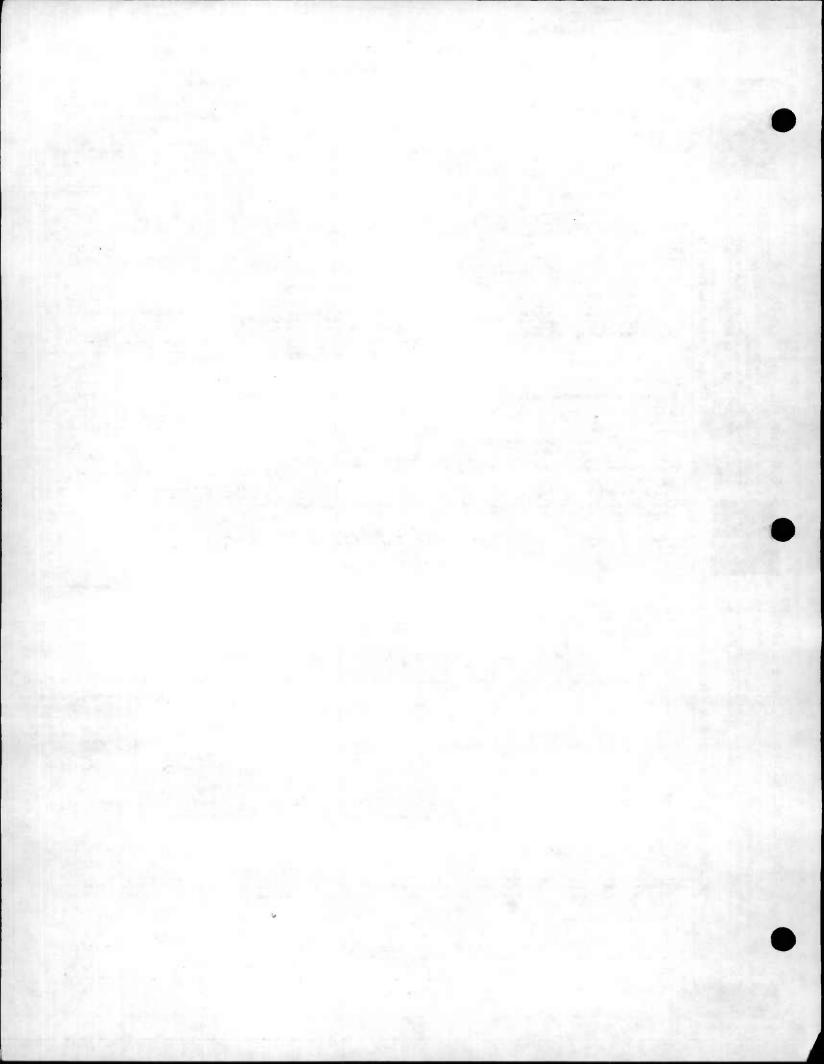
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State of Maryland / Department of Health and Mental Hygiene 0 0 1 7 7 0 0

				Certif	icate of	Death		eg. No.	10	102		
Physician	Decedent's Neme (First, Midd	2. Date of Deat Month	Dev Year		3. Time of Death							
/Medical		Landis Gre						7, 200		1:40am		
Examiner	4a Facility Name (If not institution		er)			4b. City, Town, or L		4c. County o	_			
W.	Lorien Nursing					Columbia		How	ard			
Funeral Director	5. Social Security Number 185-01-7189 Usuel Residence of Decedent	6. Sex 7. 1 □ M 2 □ F	Age (In yrs. la:		Under 1 Year onths Days							
ahow	10a. State 10b. County			Town or Location	on				100	I. Inside City Limits 1 ☐ Yes 2 ☑ No		
Pot Par		ward										
th with the Mai 23s or 28s-f a ust be notified al Director	10e. Street and Number 6441 Fairest Dr	eam Lane		1	01. Zip Code 2104	4	1	hat Country ed St				
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland d 2 should be filed within 72 hours after death with the Maryland d 1 is marked other than instructif, or items 23s or 23s-f show traumatic event, the Madical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Merried 2 Mar 3 Widowed 4 Divorced	Armed Force	1 ☐ Yes 22 No			Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - American Indien, Bleck, White, etc. Specify: White				
15-002 72 hours accelerated		nt's Education est grade completed)		16a. Decedent	s Usuel Occu	pation during most of work d)	vino	16b. Kind of Bus	iness/Indu	stry		
21215-0 ed within 72 ho ygiene. Ar then neturn it, the Medical Completed	Elementery/Secondary (0-12)	College (1-4	or 5+)	life. DO	VOT use retire	ed)	any ,	Wholesa	ale			
flied with Hygiene. ther ther ther there and, the flied with the f	12		Owner					Egg Pro	cesso	r		
and 212 be filed with that Hyglene. Id other than event, the Manager and the second and the seco	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle, I	deiden Sumeme)	7/5		
Vian Wentel Mentel Mentel To B	Monroe Greenle	V				Kate	Landis					
Maryland 2 42 should be filed th and Mental Hygis 7 ie marked other traumatic event, if	19a. Informent's Neme/Reletions	4						, City or Town, S	Stete, Zip C	ode)		
	Josephine L. Gr	eenlv/Wife		6441 F	airest	Dream La	ne Colum	bia. MD	2104	4		
S T S T S	20a. Method of Disposition 1 □ Burial 2 ☐ Cremation		0.00	ce of Dispositio netery, cremeto	n (Neme of			20c. Location - C				
Baltimore, pemir. Pages 1 at Department of Hee Important: If item 3 eny injury or othe page.	4 Donetion 5 Other (5		Met:	ro Crem	me and Addr	ess of Fecility	-10-2000					
	Shema (olins - in	Il De	Har	ry H.	Witzké's Columbia						
	23a. Pert1. Enter the disease, or complications that caused till eleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line											
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. Vetastat (Nostate Cance) Due to (or as e consequence of): b.											
He buri	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or es a consequenca of): Due to (or es a consequenca of):											
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de de de de de de de de de de de de de d	Pert II. Other significant condition	ons contributing to death	but not resulti	ing in the under	lying cause gi	ven in Pert I.	23b. Did to	bacco use cont	tribute to ti	he cause of death?		
requires that the death ce requires that the death ce ean signed by the estendi hould be deteched for use										bly 4□Unknow		
aw requires been a 2 should pleted							24a. Wes e perform		avaik	eutopsy findings able prior to pletion of cause ath?		
He ste he CO							1 □ Ye	s 200 No	10	res 2□ No		
rector, pa	25. Was case referred to medica	1				26. Place of Dee	th (Check only on	e)				
Physician: This certific ral director.	examiner?	Hospital:	atient 2 EF	R/Outpatient 3	DOA O	hor: a	ome 5 Reside		r (Specify)			
Attending Phy ir death. ector: After this by the funaral of	27. Manner of Death 1 Neturel 5 Pendir 2 Accident investi	28e. Dete of li (Month, i		8b. Time of Injury	28c. Inju		28d. Describe ho					
or Att	3 Suicide 6 Could 4 Homicide determ	ined 286. Placa of	Injury - At hom etc. (Specify)	e, farm, street,	factory, office		28f. Location (St City or Town		r or Rurel F	Route Number,		
the Hospital thin 24 hours a the Funeral mpletely filled		g Physician: To the be Examiner: On the basis end manner	of examination									
within To the comp	29b. Signature and title of certifie	2000			29c. Licen	se number	2	9d. Date signed	(Month, Da	ly, Year)		
	Marshe	World	man		H3	7211	1	WAY 8	10	0		
5	30. Name and address of person 2 KNOLL N	columbia	death (Item 2	(3a) (Type, Print)	095:	Mars	hall F	reed	nai			
State Registrar	31. Date filed (Month, Day, Year)	32. Regi	strar's Signatur	re	-	Styles in other way to				,		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

_						Ce	rtificate	of D	eath			Reg. No.			
	Physician /Medical	1. Decedent's Na Elizal		e, Last) Isabelle	Gair	nes					2. Date of De Month April	28 Day 20(OO ^{Year}		me of Death Oam
Examine		4a Fecility Name Rock G	(If not institution Len Nurs	n, give street and n sing Home	nu <i>mber)</i>				City, Town,		cation of Death	4c. Coun	ty of Death	n	
	Funeral Director	5. Social Security 219–20–0		6. Sex 1 ☐ M 2 🛣 F				ear ays	If Under 24 Hours	Hrs Vin.	8. Date of Bir (Month, Da Feb 22	th y, Year) 1913	9. Birth Con Md	nplace (S untry)	itate or Foreig
	Maryland 21215-0020 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. T is marked other than "natural", or items 23e or 28e-1 show traumetic event, the Medical Examiner must be notified at To Be Completed by Furneral Director	Usual Residence 10a. State Md	10b. County Howard	l	10c. City, Town or Location Ellicott City				У						Ide City Limits
		10e. Street end N 4910 Web		ot Way	7ay 101. Zip Code 21043							10g. Citizen of USA	Og. Citizen of What Country?		
020		3 🖾 Widowed	rried 2 Mari	led 1 Yes	a 2 X No Give	J,S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2 🖔		panic Origin Mexican, P Specify:	? (Spe uerto F	cify Yes or No Rican, etc.)	y Yes or No- lan, etc.) 14. Race - Ame Black, White Specify: bla			an,
21215-0		(Sp Elementary/Sec		st grade completed	d) (1-4or 5+)	(Give	dent's Usual O kind of work of DO NOT use r emaker	Jsual Occupation work done during most of working T use retired)			ng	domest		Industry	
land 2.	Mental Hygurked other atic event, To Be C	17. Father's Nem- Lyles	e (First, Middle,	Last)				1			(First, Middle, Thomas	, Maiden Suma	ime)		
	alth and A	19a. Informant's Joan Mar							oet and Number or Rural Route Number oot Way, Ellicott						
Baltimore,	Pages 1 and the north of the no			3 □Removal from	m State	cem <i>etery,</i> cre	osition (Name matory or othe Vn Memo	r place)		5-	Date -2-2000	20c. Location			
Ball	Physician /Medical Examiner	23a. Part Entershook on h	le disease, or or failure. List e (Final	Licansee Licansee Complications that only one cause on	(P	ter the mode o	19! f dying,	5 Syke	esVi	ille, M	eral Ho Id 21784 rrest,		Appro	iximale al Between and Death
ox 68760,	ses that the death certificate be executed geed by the attending physician end be detached for use es the bural-transit by Physician/Medical Examiner	Sequentially list if eny, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death	conditions, immediate derlying or Injury its) Last	c		or as e conse		<i>)</i> ←	cut		5			14	1
P.O. B	w requires that the death been signed by the atter should be detached for should by Physicia	Pert II. Other sign		ens contributing to			inderlying caus	se given	in Part I.		1 🗆	tobacco uee c Yes 2 No an autopsy	3 □ Pr	obably Were aut	4 ☐ Unknow
Vital Records,	aw aw		Da	lely	Mell	ely,					perio	Yes W No	0	aveilable completic of death?	in of cause
f Vital	certifican:	25. Was case referexaminer?	,	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Other			(Check only	-			20110
Division of	After fune	27. Manner of De 10 Naturel 2 Accident 3 Suicide 4 Homicide	5 Pendir investi 6 Could	pation not be 28e. Plan	e of Injury onth, Day Year) ce of Injury - At h ding, etc. (Special	28b. Time of Injury	М			2	28d. Describe	how injury occi	urred		e Number,
۵	To the Hospital or Attenwithin 24 hours after deet To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)	15 Certifyin	g Physician: To the	ne best of my kno	owledge, deat	h occurred at to	he time my opir	, date and p	lace, a	and due to the	cause(s) and r	nanner as a, and due	stated.	ause(s)
	To the within 2 To the comple	29b. Signature an	d title of cartifie	MK	el		29c. L	icense r	number	4		29d. Date sign	ned (Monti	h, Day, Y	ear)
		30. Name and ad	dress of person	who completed ca	use of death (Iter	m 23a) (Type,	Print)	2717	Hamm	ond	s Ferr	y Rd.			

Registrar DHMH 16 Rev 6/95

State

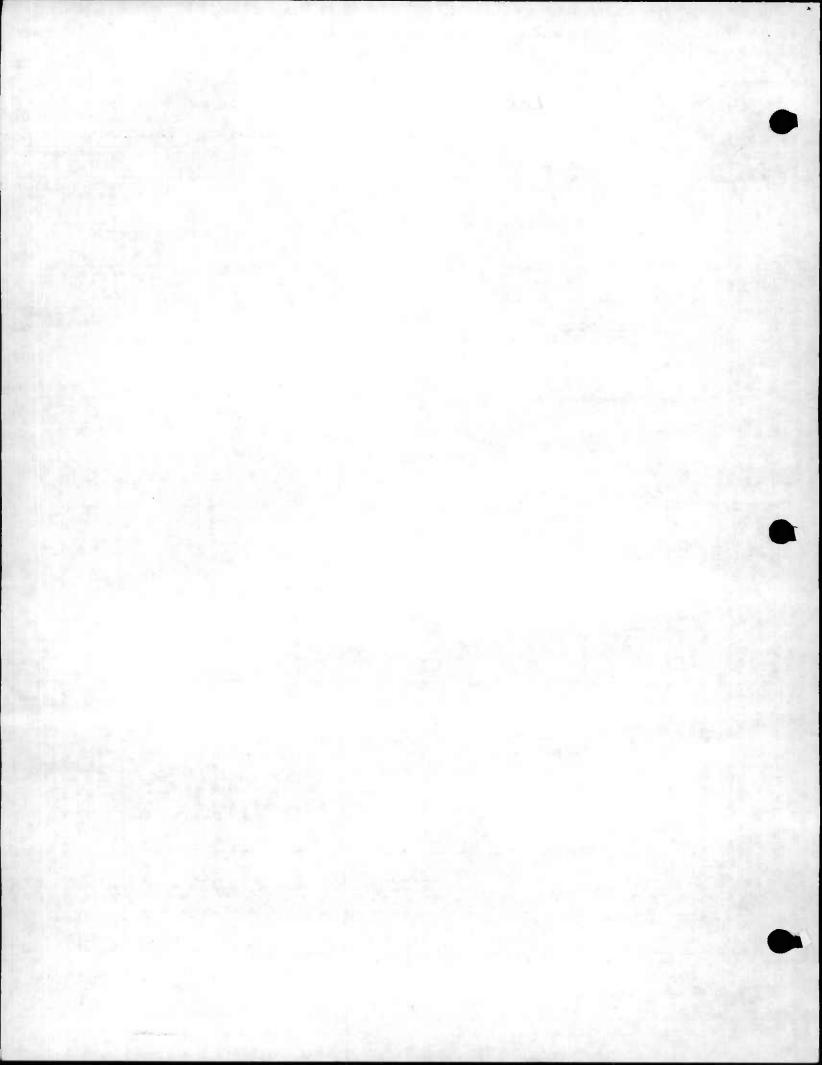
31. Date filed (Month, Day, Year)

MAY 0 1 2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year **Physician** Glovan Kichard Lee 10: 25 pm May 3000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Hopkins Baltimore Johns If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 7. Age (In yrs. lest birthdey) 5. Social Security Number 6. Sex 120 M 2□ F 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State Country) **Funeral** 219-78-7384 Director 40 July 14,1959 Washington Usuel Residence of Decedent death with the Merylend ahow ! 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 27 No Funeral Director Charles Herna 23a or 28a-f Bryans Road 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6700 Hungerford Road 20616 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Heelit and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainments. 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter Edward Glovan Marjorie Theresa Jenkins 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Walter Glovan/Father 6700 Hungerford Rd. Bryans Road, MD 20616 20b. Pleca of Disposition (Name of cametery, crematory or other plece) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from State St. Joseph's 5/8/00 Pomfret, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses AREHART-ECHOLS FUNERAL HOME, P.A. M00945 BOX 567 LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final Preumonia 2 weeks disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner 40 ycs Fibrosis STIC The lew requires that the death certificate be executed the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) pue physician Box 68760. Physician/Medical Due to (or as a consequence of): for use as signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24a. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? After this certificate hes 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No lal or Attending Physician: The safer death.

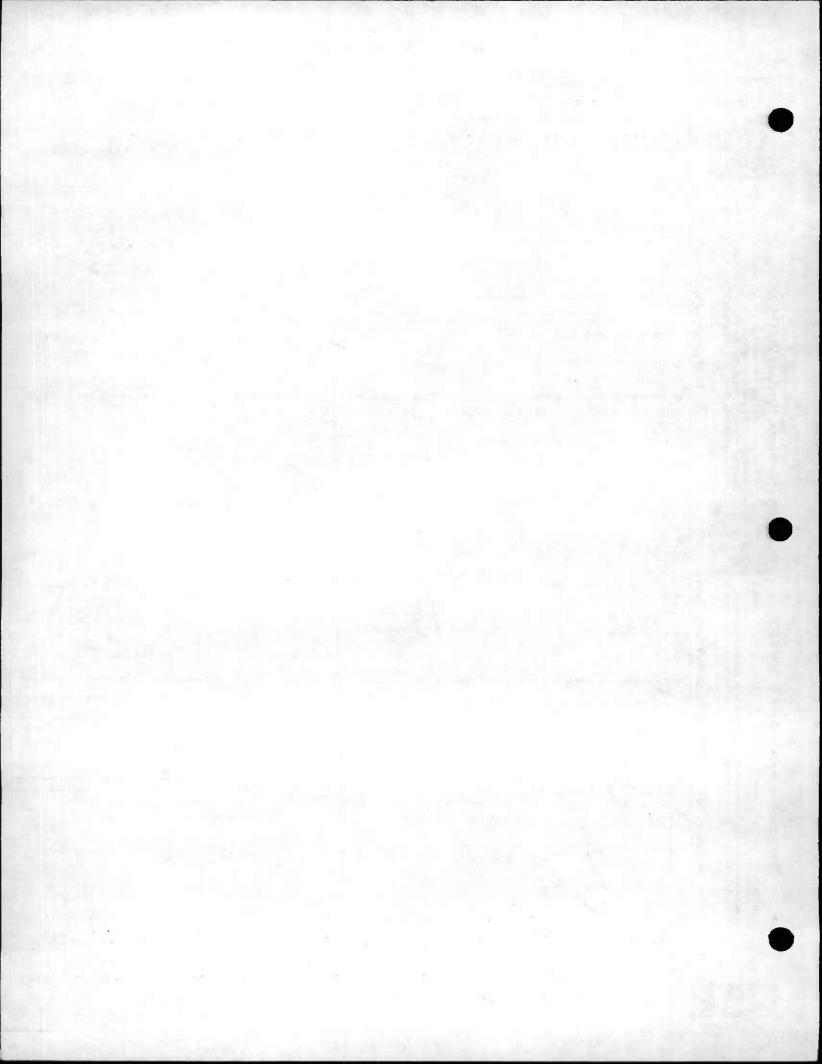
It Director: After this certificated in by the luneral director, pa 25. Was case referred to medical examiner? edical Certification: To Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ☐ ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 1 Matural 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral C 110 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steled. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and the of certifier RES-000 4, 2000 May 30. Name effd address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Hopkins Hospital, Bultimore, MD North Street, Johns 31. Dete filed (Month, Day 0 8 2000 32. Registrar's Signature State souls Registrar

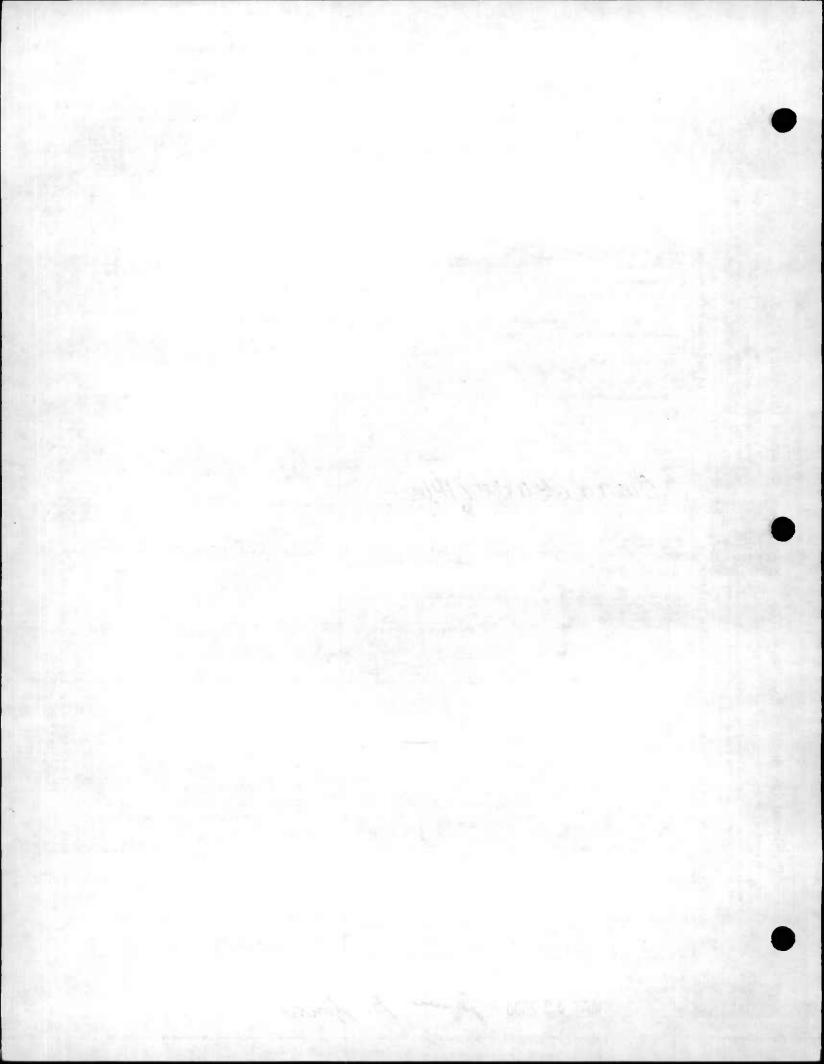


State of Maryland / Department of Health and Mental Hygiene 0 0 | 5 7 0 5

			Ce	lillicate	of De	aın		Reg. No.			
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sician edical	CATHERINE		GRAY				Мау	04, 20	000	8:40AM	
niner	4a Facility Nama (If not institution, give	e street and number)			4b. C	ity, Town, or L	ocation of Deal	th 4c. Cour	nty of Deeth		
	Civista Medica	al Cente:				a Pla		Cha	arles		
	Social Security Number 6. S	Sex 7. Ag	a (In yrs. last birthday	If Under 1		Under 24 Hrs. ours Min.	8. Data of Bi	rth	9. Birth	olaca (Stata or Foreig	
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		lee	10c. City, Town or L						1	IOd. Insida City Limit	
ı	Maryland Charl	ies	Wald	ort						1 ☐ Yas 2 Å N	
I	10e. Street and Number 4867 Leonardtow	vn Road		10f. Zip (206	01		10g. Citizen o	S.A.	ntry?	
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	1 Nevar Married 2 Married	Armed Forces? 1 ☐ Yas 2 🔀	No				Hican, atc.)		lack, Whita,		
	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Dates:		1□ Yes 2	A) No Sp	pecify:		Spec	city: Wh	re	
	15. Decedent's Ed	ducation	16a. Dece	dent's Usuel	Occupation			16b. Kind of	Business/Inc	dustry	
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	12	College (1 401	Accou	nts Re	ceiva	ble Cle	erk	Board	of Ed	ucation	
ĺ	17. Father's Nema (First, Middle, Last)				18.	Mothar's Nam	a (First, Middle	, Maidan Sum	ame)		
١	Charles Grim	nm				Jillia	n Aller	1			
ŀ	19a. Informant's Name/Ralationship (7	Type, Print)	19b. Mail	ng Address (Street and I	Number or Rui	al Routa Numb	er, City or Tow	vn. State, Zip	Coda)	
l	Rachel Morris/Gra	nddaughte	r 1158	2 Lant	ern La	ane, Wa	ldorf,	Maryla	nd 20	0602	
ŀ	20a. Mathod of Disposition		20b. Place of Disp	osition (Name	of	- 1	Deta	20c. Location	n - City or To	own, Stete	
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ı	21. Signature of Purieral Solver Licen	e e	2	2. Nama and The H	untt	Funeral	Home.	Inc.			
	The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604										
I	23a. Part1. Entar the disease, or comp shock, or heart tailure. List only	plications that caused	the death. Do not en	ter the mode	of dying, su	ich as cardiac	or raspiratory a	rrast,	1	Approximata Intarval Batween	
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	rasulting in death) Last		Dua to (fr as a consec	(uence of):					1		
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l	Part II. Other significant conditions co	ontributing to death b	ut not resulting in tha u	nderlying cau	sa givan in	Pert I.	23b. Dld	tobacco use	contribute to	the cause of death	
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ı							24a. Was	an autopsy ormed?	av	ara autopsy findings ailable prior to	
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sician	ALAN CHARLES	Month								
edical miner	4a Facility Name (If not institution, give	or Location of Death	4c. County							
	Sinai Hospital	of Balti	more		Baltin	nore	Baltin	more City		
	5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthd	Months D	ear If Under 24 F	Irs. 8. Deta of Birth	Year)	Birthplece (State or Fore Country)		
	216-54-5412 Super Residence of Decedent		50 Yrs			June 25	1949	Maryland		
	10a. State 10b. County	100	c. City, Town or	Location				10d. Inside City Lim		
Ş	Maryland Carroll		Finksh	ourg			1 □ Yes — P			
Funeral Director	10e. Street and Number			10f. Zip Co	le		10g. Citizen of Whet Country?			
ral	2517 Flagg Meadow			210		United States				
E L	11. Meritel Status	12. Was Decedent Ever Armed Forcas? * Yes 2 No	in U,S. 1	 Wes Decedent It Yes, specify 	of Hispanic Origin? Suban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		a - American Indien, k, White, etc.		
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	19e. Informent's Neme/Raletionship (1		Rural Route Numbe							
ŀ	Sondra L. Greene/v 20a. Method of Disposition	, Finksbu	burg, MD 21048 20c. Location - City or Town, State							
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	4 ☐ Donation 5 ☐ Other (Specif) 21. Signeture of Funeral Service Licen		uraney	22. Name end A	iem Garde	1	lis Stre	n, Maryland		
Phys	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): d									
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edical		ysician: To the best of my liner: On the basis of exa and menner steted.								
2	29b. Signeture end title of certiller	- 6) MD		12304/	,		29 2000 vedere Ave.		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year VIVIAN ELLEN HORNEY 22 April 2000 6:48 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Easton If Under 24 Hrs. | 8 Genesis ElderCare Talbot Pines (In vrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) 4-29-1930 9. Birthplace (State or Foreign Days 218-24-5260 1□ M 257 F MARYLAND 69 Yrs Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No MD TALBOT EASTON 10e. Streef and Number 10f. Zip Code 10g. Citizen of Whet Country? 39 MT. PLEASANT AVE. 21601 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 월 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Spacify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONTROLLER COMMUNICATIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ' UNKNOWN" WILMER RICHARDSON 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LAWRENCE W. HORNEY/HUSBAND 39 MT.PLEASANT AVE, EASTON, MD, 21601 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 24 Cremation 3 Removal from Stete CHESAPEAKE CREMATION CTR. 4-24-00STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Joseph 5truus/1. EASTON. MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) a Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

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28a-f show

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Нета 23в death

permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hyglana. Important: If item 27 ie marked other than "natural" on their treumatic averages injury or other treumatic averages.

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Director

Funeral

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within 24 hours af To the Funerel D completely filled

To the

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Records,

Division of Vital

Physician/Medical Examiner ettending physician and for use as the bunal-transit signed by t by icata has been sign, page 2 should b Completed i Hospital or Attending Physician: 24 hours after death.
24 hours after death.
5 Funerel Director: After this cartifica etely filled in by the funeral director, p. Be Medical Certification: To

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. fnjury af Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner as steted.

| Medicat Examiner: On the best of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

TYENUE

29d. Date signed (Month, Dey, Year) 00

21601

State Registrar

31. Date filed (Month, Dey, Year) APR 2 4 2000 **DHMH 16 Rev 6/95**

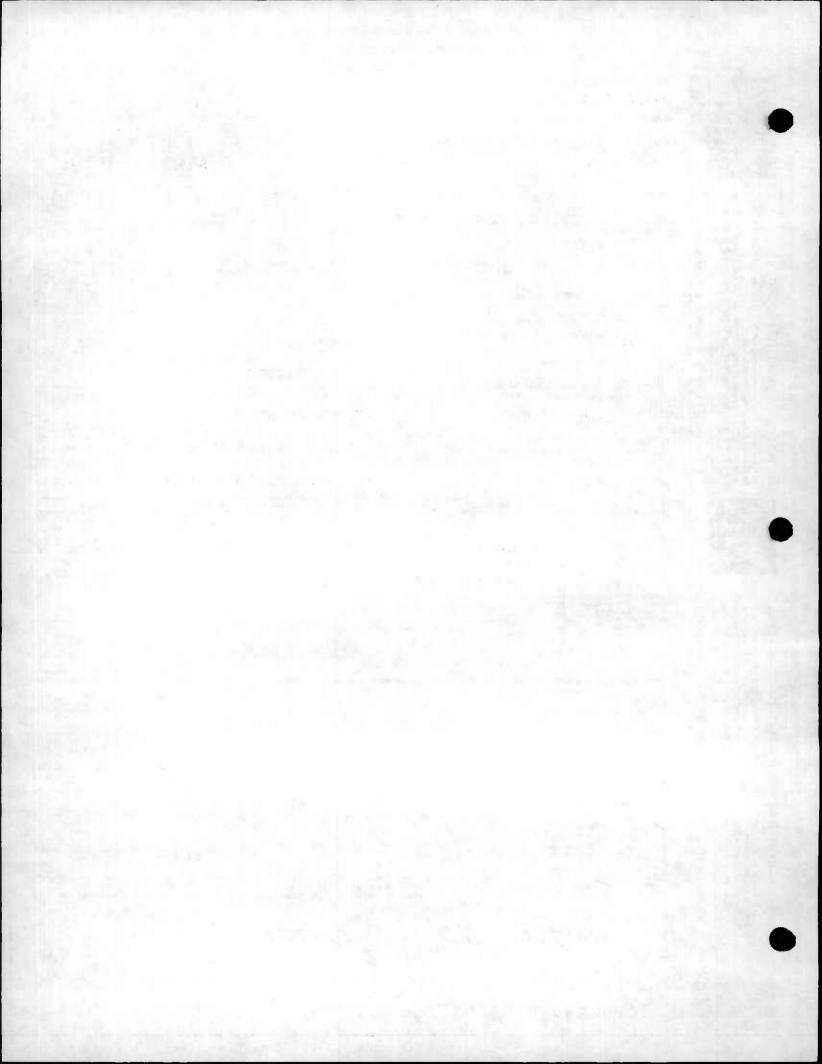
KOBL

Neme and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and fittle of certifier

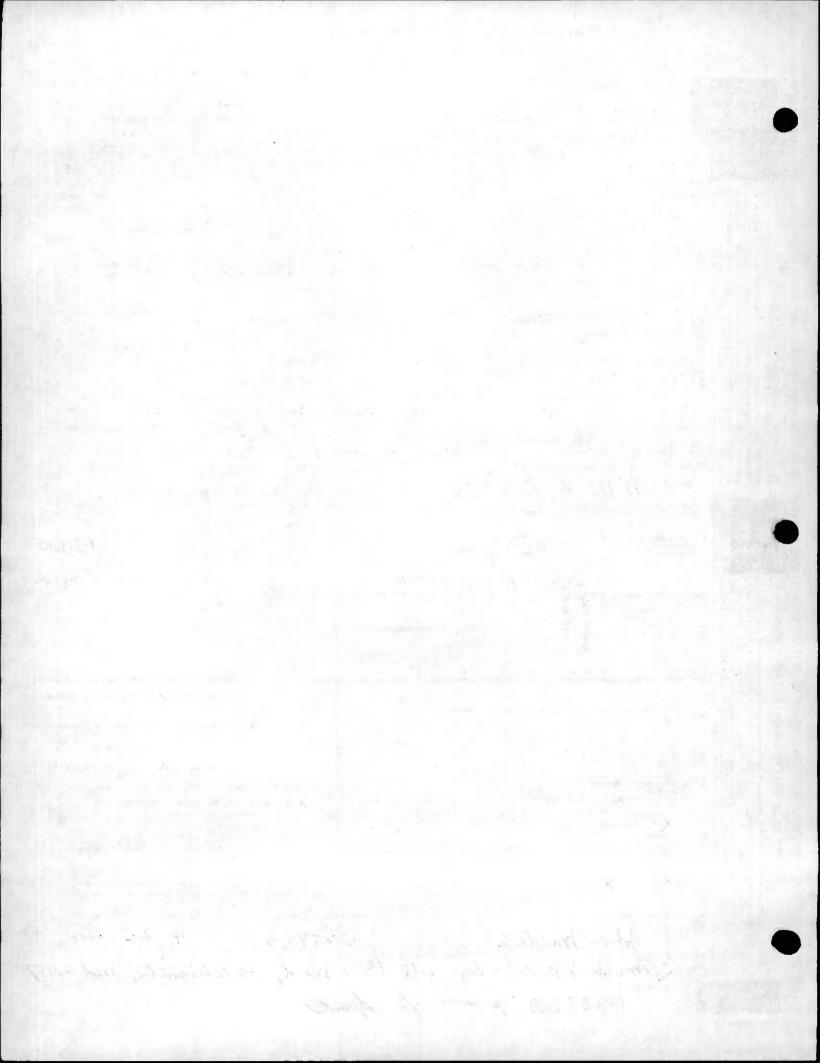
MI 32. Registrar's Signature

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0 15708

						Cer	tificate c	of Death		Reg. No.	1	0700
	Dharata	,	1. Decedent's Nama (First, Middla,	Last)			A TOTAL	100	2. Dete of D	eath		3. Tima of Daath
	Physic /Medi		George Donald H	ess					Month April	Day 25	Yaar 2000	6:21 AM
	Exami		4a. Fecility Nama (If not Institution,					4b. City, Town,	or Location of Daa		y of Daath	0.21 AII
			Westminster Nurs	ing & Rehab	Cente	r		Westmir	ster	Carr	o11	
	Funeral Director		213-20-1303	Sex 7. Age 1 M 2 □ F	a (In yrs. last 70	birthday)_ Yrs.	If Undar 1 Ye Months De		in. (Month, D	rth ay, Yaar) 6, 1929		placa (Stata or Foreign placy) yland
	and		Usual Rasidance of Decadant 10a. Stata 10b. County		10c. City, To	own or Loc	ation				1	0d. Insida City Limits
	Mary f sho	ō	Maryland Carrol	,	New 1	Windo	or					1 ☐ Yas 2XXNo
	28e	Director	10a. Straat and Number	<u> </u>	MEM	WINGS	10f. Zip Code	Α		10g. Citizan of	Whet Cour	
	3a o	ō	1801 Hoke Rd.				217					шуг
	death	Funeral	11. Marital Status	12. Was Decedant E	var in U,S.	13. W			(Specify Yas or N	U.S.A	• ce - Amaric	an Indian.
Maryland 21215-0020	pamit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, it a Mexical Evantical must be notified at once.	þ	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armad Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaer or Datas:	lo		Yas, specify C □ Yas 2🗓 N	of Hispanic Origin? uban, Maxican, Pu No Specify:	èrto Rican, atc.)	Speciii	ck, Whita,	atc.
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Ya	should be fand Mental Is marked of	2	Raymond Hess					Edna H	arner			
Jar	2 sh end is m		19a. Informant's Name/Ralationship					aat and Number or			, Stata, Zip	Coda)
	Health Health Iem 27 i		Joan T. Hess - v	vife				1., New W	indsor,	MD 217	76	
Baltimore,	of H if iter		20a. Method of Disposition 1 X Buriel 2 ☐ Cremation 3	□ Removal from State	20b. Placa cema	of Dispositary, crami	ition (Name of atory or other p	olace)	Apr. 28	20c. Location	- City or To	wn, Stata
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Sall	Depart Import any Inj once.		21. Signature of Funaral Sarvice Lic	orisaa //		22.	Nama and Add	dress of Facility	lartzler			
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	Vote III	6	23e. Part1. Enter the diseasa, or co shock, or heart feilura. List on	mplications that caused	tha death. De	o not entai	tha mode of d	lying, such as card	ac or raspiratory a	rrast,	1770	Approximate Intervat Batwaen
я	Physician		SHOOK, OF HOUR FORMULA. LIST OF	ny ona cause on aach ini	в.						i i	Onsat and Daath
H	/Medical		Immediata Cause (Finel disaasa or condition	Sylva	et.							Insun
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0	the sche	hys	Pert II. Other eignificant conditions	CONTRIBUTING TO GOART DUE	i not rasulting	in that und	ariying ceusa	givan in Pert I.				the cause of death?
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of Vital Records,	requires t een signe hould be								24a. Was	an autopsy	24b. Wa	ra autopsy findings
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Division	aling h. After fune	Certification:	1 Natural 5 Panding 2 Accident Invastigat 3 Suicide 6 Could not	on (Month, Day	Yaar)	Tima of Injury	28c. In W	ork? □ Yas 2 □ No	28d. Dascriba	how injury occur	red	
Ä	l or Attane efter deat Director: d in by the	ertifi	4 ☐ Homicida detarmine	28a. Placa of Injur building, etc.	y - At home, (Spacify)	farm, strae	it, factory, offic	е	28f. Location (City or To	Street and Numb wn, Stata)	ar or Rura	Routa Number,
	ours erai		29a. Cartifier 1 Certifying F	hysician: To the best of	my knowledg	o dooth a	accurred at the	time data and sta				
	To the Hospital within 24 hours of To the Funeral I completely filled	edical	(Check only 2 Medical Expone)	miner: On the besis of a	ixamination a	nd/or inva	stigation, in my	oplnion, daeth oc	currad at the tima.	data and placa,	and due to	tha causa(s)
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			John Mr. Y	niddle to	eth (Itam 23e)	PO	Post,	Red	11/001	- 1	h	1 2 11107
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Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yee **Physician** ROLAND AUGUSTUS HAINES APRIL 25 2000 /Medical 11:00 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 T F Yrs 216-22-7715 Director Sept. 17, 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits MD Carroll Union Bridge 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 252 Bucher John Rd. Nems 23a 21791 U.S.A. Funeral death permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if them 27 is marked other than any injury or other trausers. 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: 1950-52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) painter painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carvell A. Haines Sadie Wheeler 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene D. Patterson - daught. 2110 Autumn Oak Circle, Maryville, TN 37801 e, Date 28 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State April 4 ☐ Donation 5 ☐ Other (Specify) 2000 Mountain View Cemetery Union Bridge, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home nus 6 E. Broadway, Union Bridge, MD 21791 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** KESPIRATURY Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a const Physician/Medicai Examiner nomes attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Lest Due to (or as a conseque Records, P.O. Box 68760 Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did topacco use contribute to the cause of death? 1 1 Yee 2 □ No 3 Probably 4 Unknown Be Completed by page 2 should be 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? peen completion of cause of death? this certificate has 1 Yes 2 No 2 8 No Division of Vital al or Attending Physician: The safer death.

In Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or Atterwithin 24 hours after dea To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Allell RIM

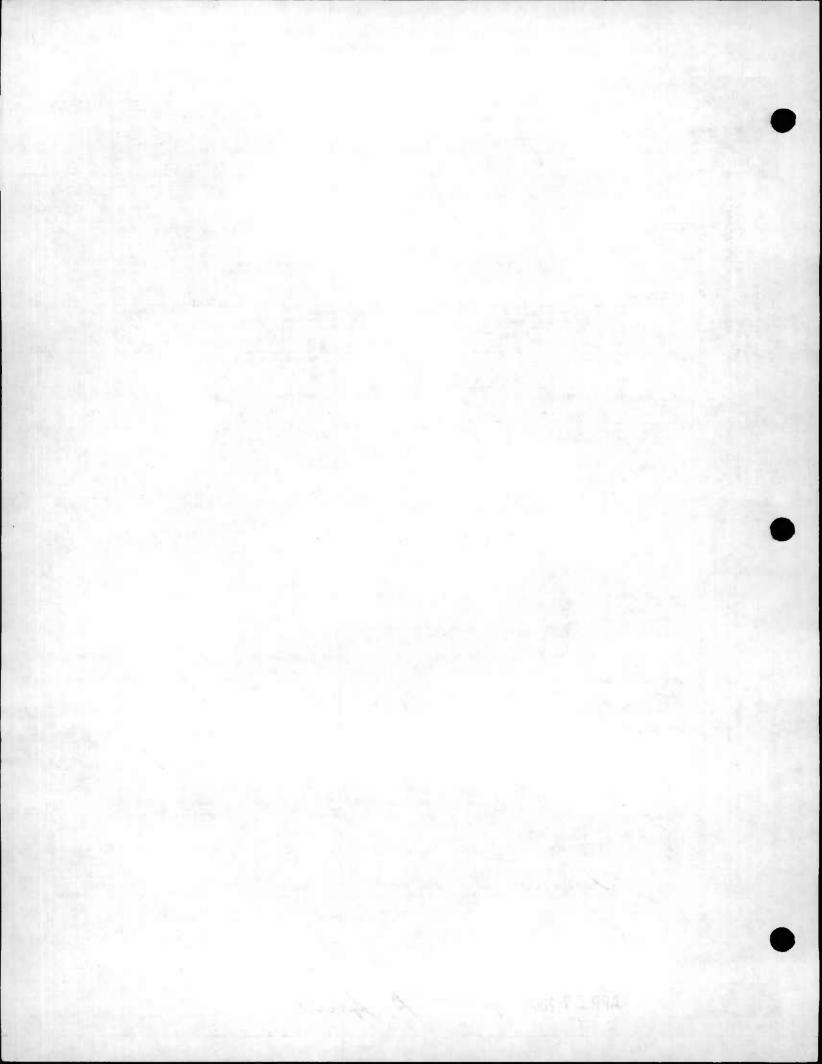
State Registrar 31. Date filed (Month, Day, Year) APR 2 7 2000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK P. KUBIW MD 201 Thomas JU 201 Thomas Jumion On

FROBLICK MD



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death APRIL Dey EROLD SR **Physician** 20 GEORGE 10 26 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner RANDALISTOUN BALTIMORE NORTHWEST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 6 Sax **Funeral** 1X M 2 F Yrs. Director 220-14-6681 /19/1925 MARYLAND Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23s or 28s-f show 1X Yes 2 No Director MD. CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 ROYER RD. 21158 USA. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 [XYes 2 □ No If Yes, Give Yeer or Detes: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Maritel Status pemit. Pages 1 and 2 should be filed within 72 hours after o Important: If Item 27 is marked other then "natural", or item any injury or other treumatic event, the Medical Examines once. Black, White, etc. 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Cottege (1-4or 5+) ASSISTANT MANAGER MATTRESS CO. 8 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) GEORGE ANDREW HEROLD ANNIE IRENE HUTTENBERG 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 310 ROYER RD., WESTMINSTER, MD. 21158 EILEEN E. HEROLD -WIFE 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 □ Donetion 5 ☑ Other (Specify) MAUSOLEUM LOUDON PARK CEM. 4/29/00 BALTIMORE, MD. 22. Name end Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Peril. Enter title disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. **Approximete** Intervel Between Onset and Death Physician ISCHAEMIC CARDIOMYOPATHY Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The iew requires that the death certificate be axecuted attending physician and for usa es the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760, Due to (or es e consequence of): Pert it. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 AUnknown Records, Be Completed by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en autopsy performed? 2 PNo certificate 1 Yes 1 Yes 2 Ho Division of Vital 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2EDNo 1) Anpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Netural 2 Accident 5 Pending after death. To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end titte of certifier 29c. License number D37733 APRIL 26, 2000 ALTO- MD 21133 30. Name end address of person who completed cause of death (ttem 23a) (Type, Print) , NHC RAVIMD 31. Dete filed (Month, Day, Year)

State Registrar

APR 28 DHMH 16 Rev 6/95

32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 29th Year ZOOO 4 pril Henry Richard Moczulski 1:557 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth (3 moral Carrel Westminster Carroll CONNY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) M 20 F 209-07-8099 85 Yrs. Feb 9 1915 Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Finksburg 1 ☐ Yes 2 ☑ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 130 Lassiter Circle 21048 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1% Yes 2 □ No WWI. If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Status 1 Never Merried 2 Married WWII 1 ☐ Yes 2 ☐ No Specify: specify.white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) mail carrier US Postal Service 17. Father's Neme (First, Middle, Last) Stanley Moczulski 18. Mother's Name (First, Middle, Maiden Surname) Josephine 19a. tnforment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lillian Moczulski (spouse) 130 Lassiter Circle , Finksburg, MD 21048 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 XOther (Specify) entombment Evergreen Mausoleum 5-3-2000 Finksburg, Md 22. Name end Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 23a Part. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of their feiture. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth WO hemorrhad Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? valve 1 Yes 2 No 3 Probably 4 Unknown alt men

Physician /Medical Examiner

Department of Health and Important: If Item 27 is m any injury or other traum 9058.

Physician

/Medical

Examiner

Md

Director

Completed

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Funeral

Director

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23a

natural, or flams

filed within 72 hours after

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Pages 1

3altimore, Maryland 21215-0020

Box 68760

SKI, HENRY

Physician/Medical Examiner þ Be Completed edical Certification: To

certificate

After this

within 24 hours after death To the Funeral Directors, completely filled in by the

death.

Attending Physician:

Hospital or

To the

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Division OC.

24a. Wes en eutopsy

2 DINO 1 Yes 26. Place of Deeth (Check only one)

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No

25. Wes case referred to medical 1 Yes 2 No 27. Menner of Death Neturel

5 Pending investigation

6 Could not be determined 28e. Placa of injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) and manner steted.

29b. Signature and title of continue

29c. License number

29d. Date signed (Month, Dey, Year) 2000

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

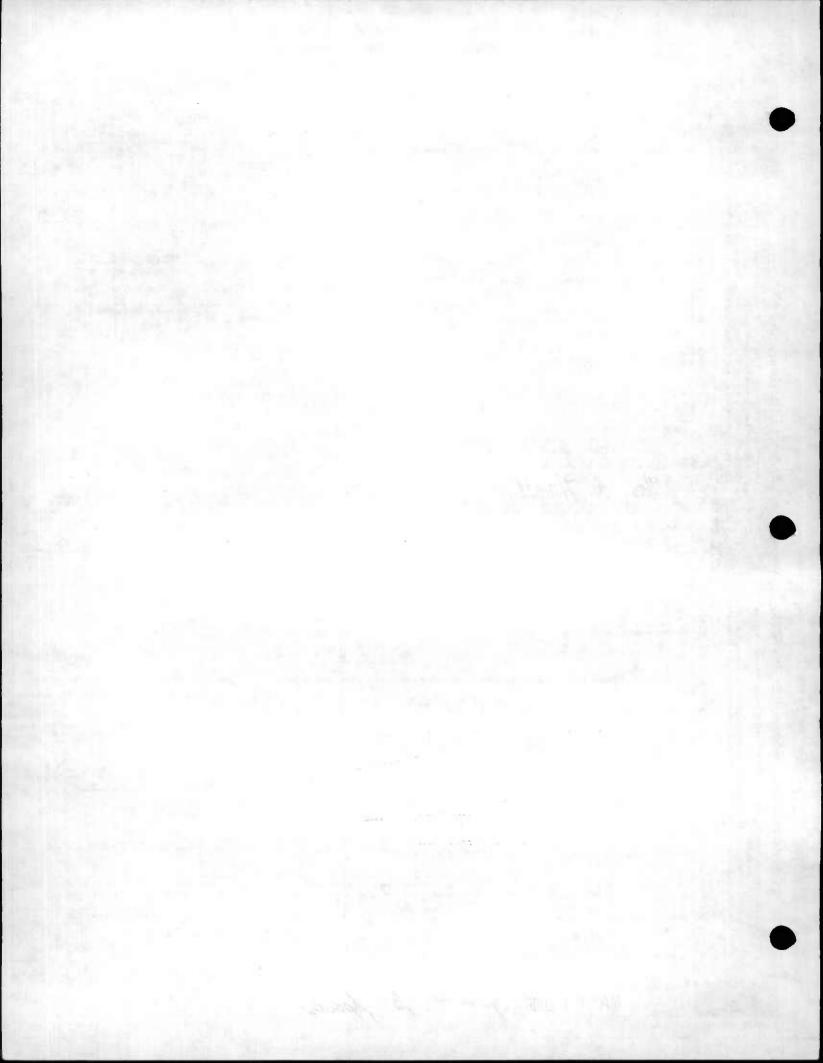
30. Name end eddress of person who completed cause of death (item 23a) (Type, Print)

200 IS O ATT moria

31. Date filed (Month, Day, Year) 0 1 2000 MAY

32. Registrar's Signature

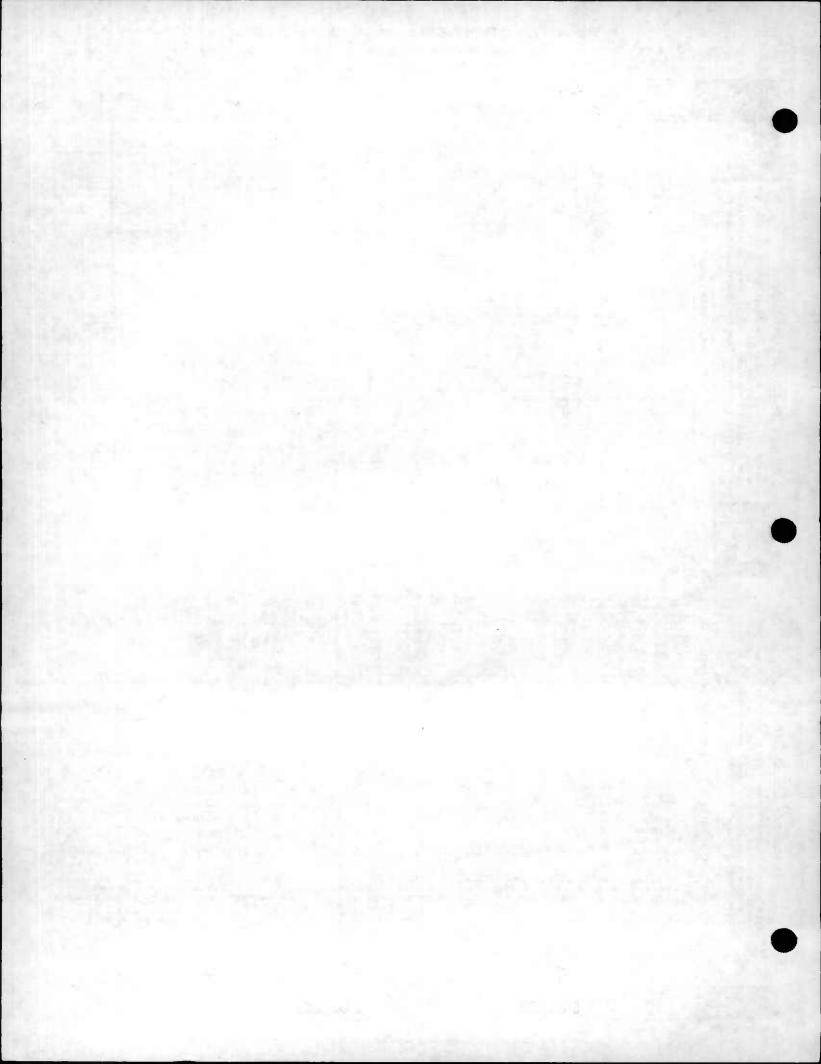
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

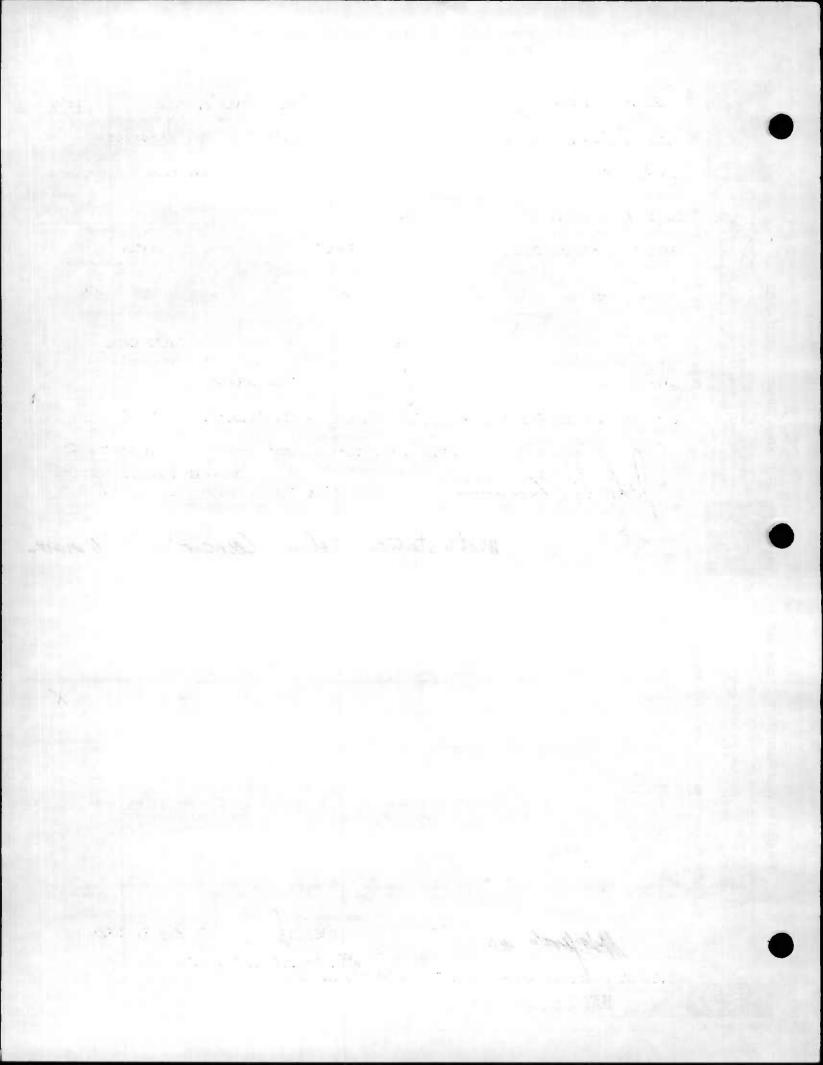
State of Maryland (Department of Health and Mental Hygiene) 15712

ITEMS: #23	2. Dete of Dee	eth		3. Time of Death	_						
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4e Facility Neme (n, giva street end number		15		4b. City, Town, or			of Death	0150 A1	-
	RSITY H	OSPITAL				BALTIMO	ORE				
5. Social Security I	lumber	6. Sex 7. A	ge (In yrs. la		If Under 1 Year Months Deys	If Undar 24 Hrs Hours Min.	8. Dete of Birth	Year) 195	9. Birthpi	iace (State or Foreign	,
216 76		ILIM ZLOSF	42	Yrs.			March '	15, 195	8 Was	hington, Do	3
Usuel Residence of 10a. Stete	10b. County		10c. City,	Town or Loc	ation				10	Od. Inside City Limits	-
Md.	Carro	011		Sykesy	ville					1 □ Yas 2000	
10e. Street and Nu	mber	12.00			10f. Zip Code			10g. CitIzen of V	Whet Count	try?	
5660 W	allace	Court				21784		U.S.A	A.		
11. Maritel Status		12. Wes Decedan Armed Forces		. 13. W	les Decedent of	Hispanic Orlgin? (S een, Mexican, Puer	Specify Yes or No-	14. Rac	e - America		
		fled 1 ☐ Yes 2 ☑ If Yes, Give	No		□ Yas 2 No		, 5 (1154.1)		w Whi		
3 Widowed		Year or Detes		16a Danad	antic United Once	nation					_
	city only highe	t's Education st grade complated)		(Give k	ind of work done O NOT use retire	pation during most of wo d)	rking	16b. Kind of Bi		ustry	
Elemantery/Second	ondery (0-12)	College (1-4or	5+)		onal Tra			Fitness			
17. Fether's Neme	(First, Middle,					18. Mother's Na	me (First, Middle,				-
Allen	H. Morr	ris				Maril	yn M. Car	rroll			
19e. Informent's N	ame/Ralations	thip (Type, Print) (sp Lip Harris	ouse)			t and Number or R				Coda)	Ī
		tip nailis				Ct. Syke			1784		
20a. Method of Dis		3 ☐Removel from Stete	Cei	metery, crem	ition (Neme of etory or other ple		Date /0 /2000 T	20c. Location -			
4 Donation			Piec			metery 5					_
21. Signature of Fi	Inerel Service	Haraht		22.	P.O.Box	ass of Facility Ha 195 Syk	ight Fun esville,	eral Ho Md. 21	me & 784	Chapel	
23a. Part1. Enta	ha disaase, or	complications that cause only one cause on aach	ed the deeth.	Do not ente	r the mode of dy	ing, such es cardia	c or raspiratory er	rast,		Approximata Intarval Batween	_
			7.7							Onset end Deeth	
Immediete Ceuse diseasa or condition rasulting in deeth)	(Final	Θ	HEAD I	NJURY					1		
				es a consequ	iance of):				1		
		b	A FALL						-		_
Sequentially list or if any, leading to in cause. Enter Und Cause (Disease on that interest work	nditions, nmediate		Due to (or	es e consequ	iance or):						
Cause (Disease or thet initiated event	9	c	Due to (or a	as e consequ	ance of):		_				_
Cause (Disease of thet initiated event resulting in deeth)	La5l								1		
1-0		d									
Pert II. Other signi	lcant condition	ons contributing to death	but not result	ting in the un	derlying cause g	iven in Part I.	23b. Dld t	1	ntribute to	the cause of death?	7
SEIZUR	E DISOR	DER AND CHR	ONIC A	LCOHOI	LISM		10	100 2/X No	3 ☐ Prot	bably 4 Unknow	n
							24e Wes	en autopsy	24b. We	ere eutopsy findings	-
								med?	ave cor	ellable prior to	
							1,86	res 2□No	1	death?	
25. Wes case reference	red to medica			-		26 Place of De	eth (Chack only o	-	VI.	9 195 2LINO	_
examiner?		Hospital: XX Inpai	iant 2 E	R/Outpatient	3□ DOA O	hor	Home 5 ☐ Resid		er (Specifi	y)	
	h	28e. Date of In	ury	28b. Time of	28c. Inju		28d. Describe t			174.0	
27. Menner of Dee	5 Pendin investi	gation 5-3-00	(EST)	UNK		Yes 2 No	SUBJEC'	r FELL			
3 ☐ Suicide 4 ☐ Homicide	6 Could	ined 289. Plece of It	njury - At hon	ne, farm, stre	et, factory, office		28f. Location (S City or Tox	Street end Numb	er or Rure	LLACE CT.	Ī
	The same			ESIDEN	CE		SYKES	VILLE,	MĂRŸĹ	AND ST.	
29a. Certifier (Check only one)	1☐ Certifyin 2∑Viedical	g Physician: To the bes Examiner: On the basis	of examinetic	ledge, deeth on and/or Inve	occurred at the t estigation, in my	ime, date end plec opinion, deeth occi	e, end due to the curred et tha tima,	ceuse(s) end medata and place,	enner as st and due to	ated. the cause(s)	
29b. Signature and	2141	and manner s	teled.			se number		29d. Deta signe			_
SSS. Organicare and		1.100	1.1			C.M.E	8000 F		06 ,		
20 Nome 1 - 1		1111111	V death in	22-) (7: -							_
	K M	who completed ceuse of				D-11/		2 2 01			
JAC	K EVIII	11(1) 11/1/1	11.	r remi	Street	Baltimo	re, Marv	Land 21	201		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Dete Month V 2, 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** BARBARA J. HOLLY MAY 2000 1:40 PM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** 3229 Indian King Court Waldorf Charles If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yaer) Birthplece (Stete or Foreign Country) 5. Sociel Security Number **Funeral** Deys Hours 10 M 20 F Yrs. Director 220-50-8001 49 May 28, 1950 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f show solical Examiner must be notified at Yes 2 No Maryland Waldorf Directo Charles 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? With 20602 3229 Indian King Court permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or item 23 any injury or other traumatic event, the Medical Examinar must Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 Yas 2 No If Yes, Give X Yaer or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greda completed) Elementery/Secondary (0-12) College (1-4or 5+) Cook Child Care 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Jane Dotson Albert Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Shannon L. Holly-Washington 12141 Ell Lane #17 Waldorf, MD 20602 20b. Placa of Disposition (Name of cametary, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Bunal 2 Cremetion 3 Removal from Stete 4 Dogation 5 Other (Specify) 5-8-00 Trinity Memorial Gardens Waldorf, MD of Fugeral Spring Licens 21, Signat 22. Name end Address of Fecility Eberwein Funeral Services M00173 ven 4433 White Pls La White Pls., MD 20695 Finter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, k, or heart failure. List only ona causa on each lina. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Metanteitie Colon Councer Examiner Due to (or es e consequence of): Physician/Medical Examiner physician and s the buriel-transit The lew requires that the death certificate be executed Sequantielly list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequance of) use as ettending | signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been sig 24a. Was an autopsy Completed s certificate has l 2. No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica director, 25. Was case raferred to medical exeminer? Be 26. Pleca of Daeth (Chack only one) Other: 4 ☐ Nursing Home 5X Residenca 6 ☐ Other (Specify) 1 ☐ Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how injury occurred Naturel 2 Accident 5 Pending Injury 1 Yes 2 No Investigation 6 Could not be datarmined To the Hospital or Atte within 24 hours efter de To the Funeral Directo complately filled in by the 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to tha causa(s) and mannar as statad.

| Description of the basis of examinetion and/or investigation, in my opinion, daeth occurred et the time, date and place, end due to the cause(s) 29a. Certifier edicai end menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number D46246 May 3, 2000 30. Name and atting in who completed cause of deeth (Item 23e) (Type, Print) M. Ashraf Meelu, M.D. #10 St Patricks Drive Suite 105 Waldorf, MD 20603 31. Date filed (Month, Day, Yeer)
MAY 0 5 2000 32. Registrar's Signature State Geneva Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 11:02 pm 7, May Pearl M. Johnson 2000 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3041 Bethany Lane Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 21, 1 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Yrs. Director 216 28 3833 72 1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Howard Ellicott City 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1.

Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or flams 23a and Injury or other traumatic event, tra Medical Examples 200. 3041 Bethany Lane 21042 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes, 2 ☒ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marilal Status 1 ☐ Never Merried 2 ☐ Merried 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Housewife Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Maurice F. White Dola Armstrong 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Toliver/Daughter 3041 Bethany Lane Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hopkins U. M. Church Cent5-12-2000 Highland, MD 21. Signeture of Funeral Service License MOLD 22. Name and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner mome physician and s the burial-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Renal Records, ata has been signe page 2 should be 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 No certificata of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home \$15 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Neturel 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

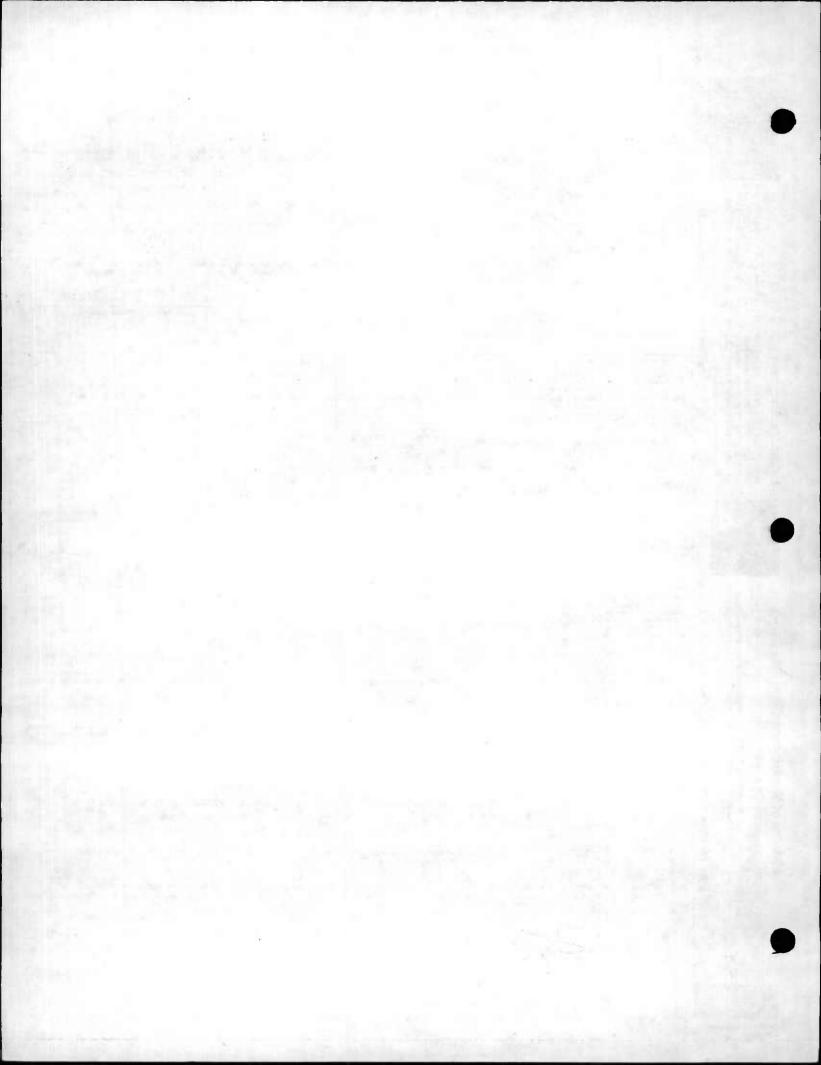
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4515 5 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mAUNG MADEN CHOICE LANG 0. 716

State Registrar 31. Dete filed (Month, Day, Year)

MAY 0 9

2000

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Daath Month Year ~ GAN **Physician** Patricia Faye Jacobs May 2000 /Medical 4a Facility Nama (II not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ellicott City Avoca Ave. Howard If Under 1 Yaar Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days 1 M 25 F Yrs. Director 212-30-8262 66 Sept. 17, 1933 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show striner must be notified at 1 Yas 20No Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5005 Avoca Ave. 21043 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yas, Giva Year or Datas: 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced white 16a. Decedent's Usuat Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is marked offer any Injury or other traumatic event anse. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) å Charles E. Healey Eunice L. Benton 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Michael J. Merenda / son 1116 Flamingo Rd. Venice, Florida 34293 Saltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata May Data 9 € Burial 2 Cremation 3 Removal from Stata Lorraine Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Baltimore, Maryland 22. Nama and Addrass of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD. 21043 NOIDA Approximate tnterval Between Onsat and Deeth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. **Physician** Immediata Causa (Final disease or condition resulting in death) · Atherosdevotic Cardiovascular Disease /Medical Teak. Examiner Dua to (or as a consequence of). Examiner typertension 1eavs physician and s the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or tripiny that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease P.O. Box 68760. Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ been signe should be 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of causa of death? 1 Yas 2000 1 Yas 2 No of Vital or Attanding Physician: 8 25. Was casa referred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1⊠ Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury et Work? Division ve Hospital or Attanding in 24 hours after death. the Funeral Director: After roletely filled in by the fun-1 Natural 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, Stala) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and menner as stated.

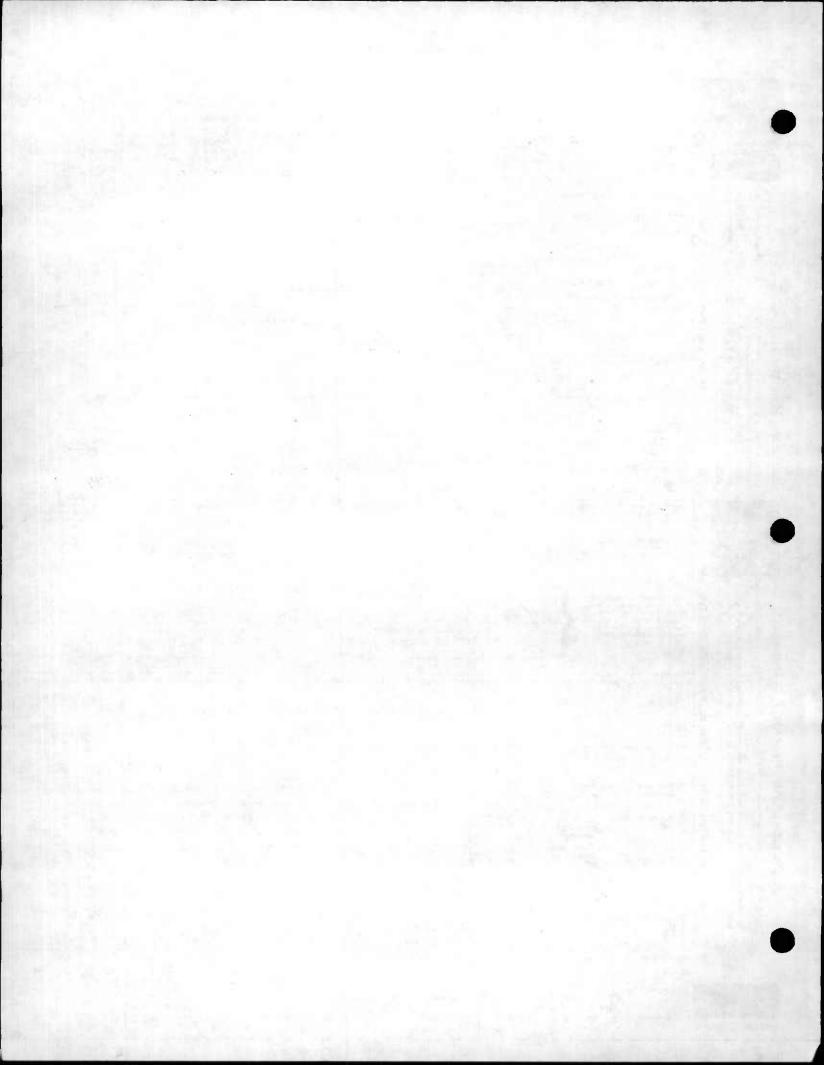
2 Exeminer: On the basis of axaminetion and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) \$ 29c. License number 29d. Dete signed (Month, Day, Year) Deput May 6, 2000 D31473 LWYD ME 10 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) PATRYCE A. TOME, MD 4565 Hemlock Cone Way Elliately MD 21042

DHMH 16 Rev 6/95

State Registrar

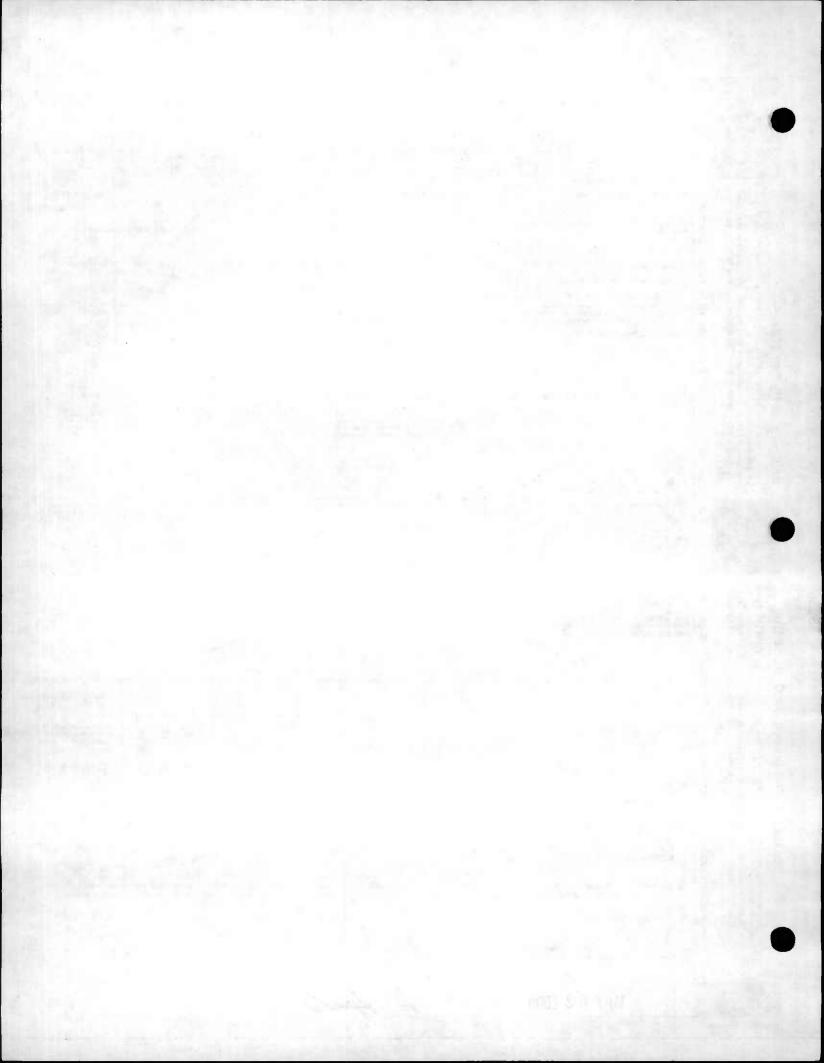
31. Date filed (Month, Day, Year) MAY 08 2000

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

			Certific	cate of Death		Reg. No.	15/16			
Dhusisian	1. Decedent's Name (First, Middle, La	ist)			2. Date of De Month		3. Time of Death			
Physician /Medical	Anne Darlene	defler.	2		Auril		000 11 AM			
Examiner	4a Facility Name (If not institution, gir	ve street and number)		4b. City, Town,	or Location of Deat	4c. County of	Death			
	Carroll County G	eneral Hospita	al	West	minster	Ca	rroll			
Funeral Director	214-40-6873	Sex 7. Age (In yrs	Yrs. In the state of the state	nder 1 Year If Under 24 ths Days Hours I	Vin. (Month, De	th ly, Year) 1,1941	9. Birthplace (Stete or Forei Country) Maryland			
D	Usual Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Location				10d. Inside City Limit			
within 72 hours after deeth with the Maryland ane. Then 'netural', or items 23e or 28e-f show the Medical Examinar must be notified at the Medical Examinar must be notified at the Medical Examinar must be notified at			,	Hamps	beat		1 ☐ Yes 2 ☑ N			
or 28e-f	Maryland Carrol	1	1.00		ccaa					
23a or	10e. Street and Number 3810 Sunnyfield	Ct, 3-C	101	Zip Code 21	074	10g. Citizen of Wh USA				
ral', or items 23s or 28s-1 show Essentine must be notified at I by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in I Armed Forces? 1 ☐ Yes 2⊠ No If Yes, Give Year or Dates:		ecedent of Hispanic Origin's specify Cuban, Mexican, Pos 2 No Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Race Bleck, Specify:	American Indien, White, etc. White			
or than "netural", ft. fre trades Ex.	15. Decedent's E (Specify only highest gr		16a. Decedent's	Usuel Occupation f work done during most of	working	16b. Kind of Bus	ness/Industry			
then the	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)	WORKING					
Hyglene. ther ther ent, the	12		Execut	ive Secretar	У	Life 1	nsurance			
T 5 5 A	17. Father's Name (First, Middle, Last)		18. Mother's	Neme (First, Middle	, Maiden Surname)			
Mental arked o atic eve To Be	Henry Edward Sny	der, Jr		Lau	ra Ellen	McKitric	ζ			
e mar	19a. tnformant's Name/Relationship (Type, Print)	19b. Meiling Add	Iress (Street end Number o	r Rural Route Numb	er. City or Town, S	tete. Zip Code)			
th end Men 77 is marke Treumatic	Steven Jeffers,	son		rown Rd, Tan						
f Health Item 27 I other tr	20a. Method of Disposition	20b.	Place of Disposition	(Neme of	Dete		ity or Town, Stata			
0 = x	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	Removel from State	cemetery, cremetory	or other piece) 'k Cemetery	5/1	Baltimo				
Department Important: I eny Injury o	21. Signature of Funeral Service Lice	M007:	27	e end Address of Fecility 4 South Main		Funeral H stead, MI				
	23a. Part1. Enter the disease, or com shock, or heart teilure. List only	plications that caused the dea	ath. Do not enter the	mode of dying, such es car	diac or respiratory a	rrest,	Approximate			
ysician	snock, or near tenure. List only	one cause on eech line,					Onset and Death			
Medical	Immediete Causa (Final	C					1			
aminer	disease or condition resulting in death)									
- L	Due to (or es a consequence of):									
n end iel-transit Examiner		o. Metas f	otic 1	nala	Concer		rundes			
physicien and set the burlei-transit edical Examin	Sequentially list conditions, if any, leading to immediate	Due to (or es a consequence	of):			F - 1 (4) (4)			
ren m	cause. Enter Underlying Cause (Disease or injury									
physicies the bur edical	that initieted events resulting in death) Last	C. Due to (or es a consequence	of):						
Med Med	1000ting in Code / Last									
for use		d					1			
d for	Part II Other elections and lines	antillization to death his and an	and the state of the state of		l ant bil		45			
ed by the attend detached for us Physician/	Pert II. Other significant conditions of	contributing to death but not re-	suiting in the underlyi	ng cause given in Pert I.			fibute to the cause of dea			
deta deta					10	Yes 2□ No 3	B Probably 4 Unkn			
should be						an autopsy ermed?	24b. Were autopsy finding evailable prior to completion of cause of death?			
pege 2										
of Page					10	Yes 2 No	1 ☐ Yes 200 No			
is certificate director, peg To Be Co	25. Wes case referred to medical examiner?	Magaital.			Deeth (Check only	one)				
0 0 E	1□Yes 2⊠ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursir	ng Home 5 ☐ Resi	dence 6 □Other	(Specify)			
After th funeral flon:	27. Manner of Death 1 Matural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe	how injury occurred	1			
the fu	2 Accident investigation		М	1 ☐ Yes 2 ☐ No						
al Director: After teled in by the funeric	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		nome, farm, street, fe	ctory, office	28f. Location (City or To		or Rural Route Number,			
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Within To the comple	29b. Signatura and pitting certifier			29c. License number		29d. Date signed	(Month, Day, Year)			
8 = 8	1 /Chr. man			A						
	A MEN	Anne Company		10040525		April 2	7, 2000			
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	200 memorial	Ave., Westm	NSTER, M-	21157			
	Ruch / Iltani	, m.n. (a	rroll Co	centy Ge	neral	Hospile	1 -			
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature /	1		-				
Registrar	MAY 0 2 2	non Deneura	9	Ana VI						



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2000 LILLISTON May 2, MYRTLE WILKERSON 6:55 AM /Medical 4a Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DIXON HOUSE EASTON TALBOT If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 6,1910 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√F Virginia Yrs Director 214-30-8505 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 28a-f ahow 7 is marked other than "natural", or ferma 23s or 28s-f shot traumatic event, the Maoical Examiner must be notified as 1 Tyes 2 □ No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with it Department of Heelih and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Mexical Examinat must be as once. 108 North Higgins St 21601 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - Amarican Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Be Completed by White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Bookkeeper Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Wilkerson Taylor Manie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean L. Morse/Daughter 903 S. Talbot St., St. Michaels, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Surial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Pitts Creek Presbyterian Cemetery 5/5/00 Pocomoke City, MD 21. Signature of Funeral Sarvice Licensae 22. Nama and Address of Facility Holloway Melson Funeral Home Professional Assoc. mo1129 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailure. List only one cause on each line. **Physician** ARDIOVASCULAR DISEASE /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Physician/Medical Examiner ettending physician and for use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be assocuted Ze hours afrected death.

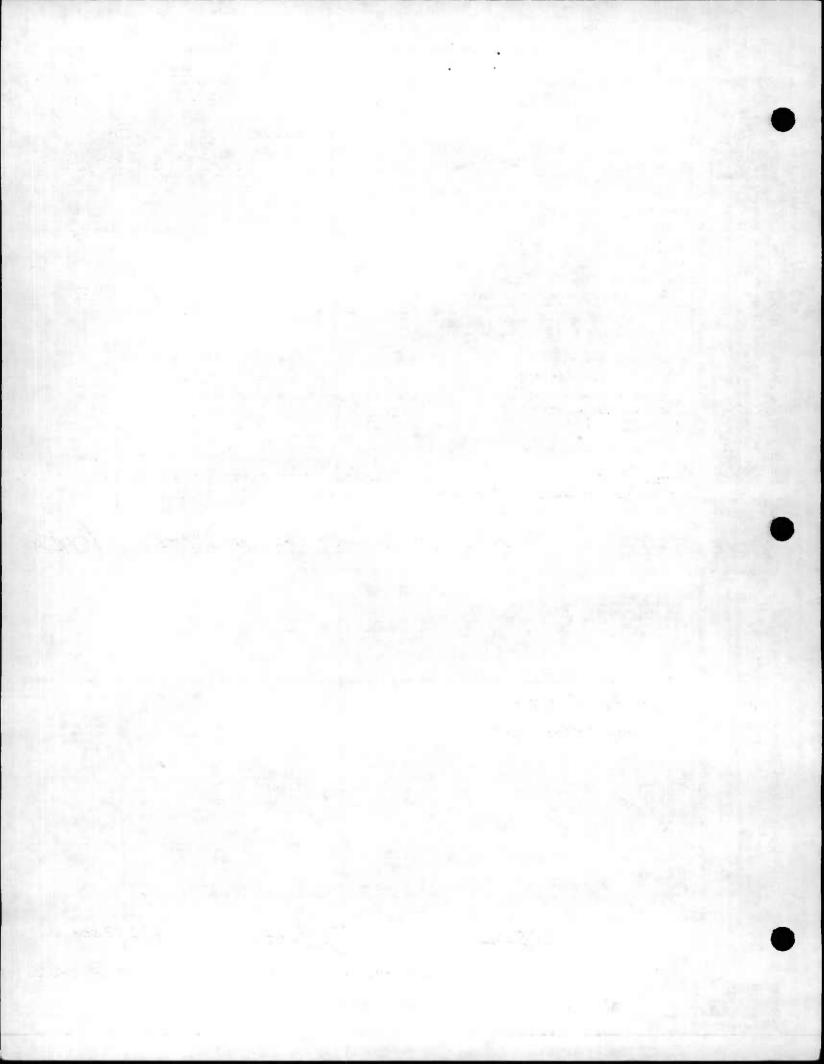
24 hours afrector: Afrecthis certificate has been signed by the ettending physician and alter the type of the transmission and the strength of the streng Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 | Yes 2 No 3 □ Probably 4 □ Unknown HYRRLIPIDFMIA Records. þ HYPOTHYROIDISM Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 28 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending Investigation Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral E Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26350 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 800 S. Talbot St., St. Michaels, MD 21663 William S. Bremer, M.D. 410-745-2020

State

MAY 0 4 2000 Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature



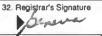
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 2000 **Physician** LILLIAN WHITCRAFT LITTLE 29, 11:00 AN April /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4320 Geeting Road Westminster Carroll 8. Dete of Birth (Month, Day, Year)
May 31, 19 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 9. Birthplace (State of Foreign Country) **Funeral** Days Months Hours Min TOM MOF Yes. Director 76 Maryland 216-22-8752 permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or here 23a or 28a-f show any injury or other traumetic event, to Medical Examine must be notified anonce. 10a. State 10c. City, Town or Location 10d, inside City Limits 10b. County 1 ☐ Yes 2 No Directo Carroll Maryland Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4320 Geeting Road 21158 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 210 No Specify: Specify: þ 3 Midowed 4 Divorced White Yeer or Detes: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 11 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be John Ford Crissinger Mae Maurine Myers ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy C. Staub/daughter 1489 Western Chapel Rd, New Windsor, MD 20b. Placa of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition XIX Buriai 2 ☐ Cremetion 3 ☐ Removal from State Finksburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Evergreen Memorial Gardens 5/2 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers Funeral Home 91 Willis Street 21157 Westminster, MD WESTRILY

23a. Part1. Enter the disease, or complications that caused the deal Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervei Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner ettending physician end for use es the bunel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequenca of): signed by the elid be detached for Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably þ 24b. Were eutopsy findings evailable prior to complete? bleen si 24a. Was an eutopsy Completed hes de 2 ils certificate her 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral d 27. Mapher of Death 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 1 Naturai Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funerel Directompletely filled in b 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 05-01-00 D33561 address of person who completed cause of death (Item 23a) (Type, Print) Name James L. Forsberg M.D. 912 Washington Road, Westminster, MD 21157

State Registrar

31. Date filed (Month, Dey, Year) MAY 02 2000



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month May 2, 2000 RUBY K. LORD 0750 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Carroll County Westminster Carroll County General Hospital If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) Months Days Hours 1□M 2\ F 95 Yrs. 214-28-5807 Oct. 17,1904 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 N No Carroll County Taneytown Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21787 4485 Harney Road United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3K Widowed 4 □ Divorced Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sociology scciologist 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unknown) Floyd Norman King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Taneytown, MD 21787 Mildred Bollinger / friend 3526 Old Taneytown Road 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) May 4, 2000 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Taneytown, Maryland 4 □ Donation 5 MOther (Specify)Entombment Piney Creek Presbyterian 21. Signature of Edneral Service License 22. Name and Address of Fecility Skiles Funeral Home the M. Stiles M00534 136 East Baltimore Street Taneytown, MD 21787 Approximate Intervat Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) SEPSIS Due to (or es a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of) Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown INFARCTION 24b. Were autopsy findings sveilable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 14 No

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

Examiner

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Incortain: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

ettending physician and for use es the buriel-tren signed by the e is certificate has t director, page 2 s

by

Completed

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Certification:

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29a. Certifie

29b. Sign

The law requires that the death certificate be executed the Hospital or Attending Physicien: in 24 hours efter death. the Funeral Director: After this certifica upletely filled in by the funeral director, p

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Division of Vital

State Registrar

examiner? 1 Yes 2 No 27. Menner of Death 1 Natural

25. Was case referred to medical

2 Accident 3 Suicide 4 ☐ Homicide

5 Pending investigation

6 Could not be determined

1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year)

28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 28c. fnjury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

26. Place of Death (Check only one)

281. Location (Street and Number or Rurel Route Number, City or Town, State) Till Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

nd title proentitier

Hospital:

29c. License number D51245 29d. Date signed (Month, Dev. Year)

200 Memorial Ave. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARIF SAJID

CARROLL COUNTY HOSPITAL

28b. Time of

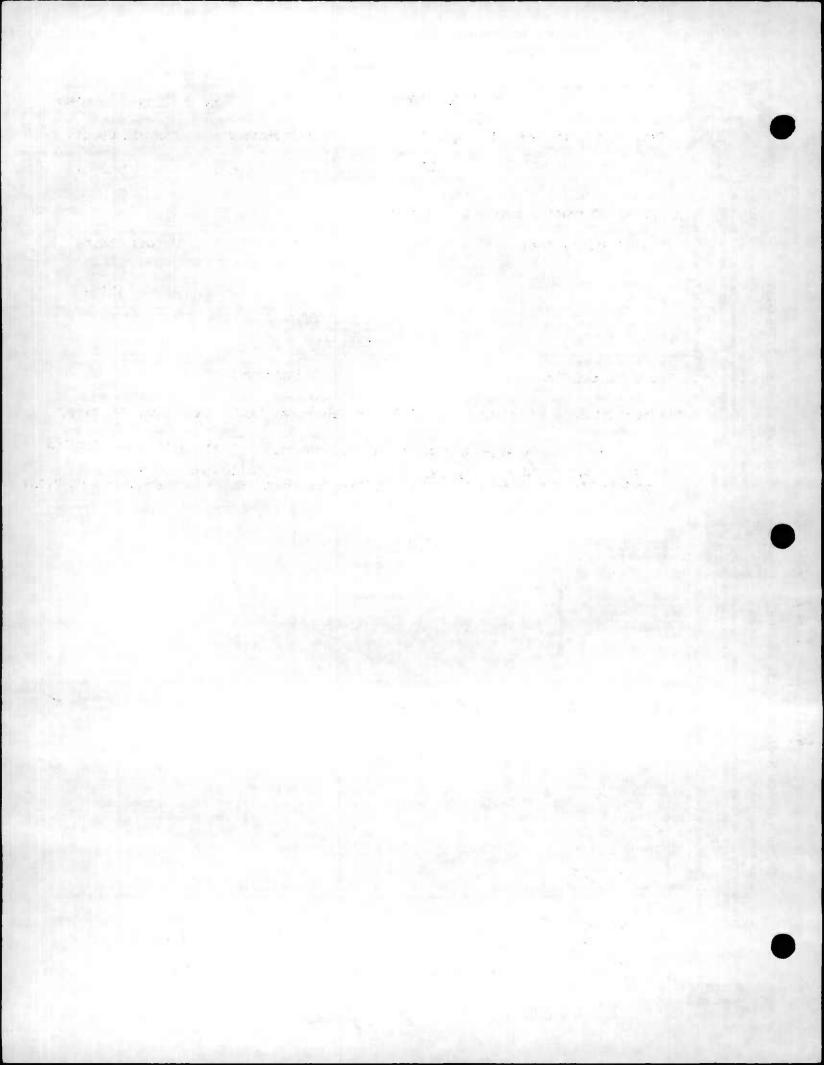
WESTMINSTER, MD

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene amend ite 24a per phys. G786 8/7/00 yg Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** 19, 4:45 AM Kenneth Ray Lewis, Sr. April 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1639 Fairhill Drive Edgewater Anne Arundel H Undar 24 Hrs. 8. Data of Birth Hours | Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days 1XM 2□ F Director 408-60-4241 60 1940 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importante Hitem 27 le marked other than "natural", or heme 23e or 28e-f ahow any injury or other traumate event, the Medical Exercise man be notified as 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Maryland Anne Arundel Edgewater 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 1639 Fairhill Drive 21037 USA Funeral 12. Was Decedenl Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Never Married 2 ☑ Married 1 ☐ Yas 2 ☐ No If Yas, Give A Year or Dates: Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver School Bus 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) 8 John A. Lewis Mamie Morris 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Royetta K. Lewis/ Wife 1639 Fairhill Drive Edgewater, Maryland 21037 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stella Lakemont Mem'1. Gardens 4-22-00 Davidsonville, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Părt1. Enter tha disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart taitura. List only ona causa on aach lina. Physician /Medical Immediata Causa (Final disease or condition resulting in death) Cancer Examiner Dua to (or as a consequence of): Physician/Medical Examin or Attending Physician: The law requires that the death certificate be assecuted Sequentially fist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): attending physician and for use as the burial-tree 68760. Dua to (or as a consequanca of) Box P.O. I Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? signed by 1 Yes 27 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate 1 ☐ Yas 2 X No t ☐ Yas 2 ☐ No Division of Vital 25. Was case refarred to medical 8 26. Placa of Death (Check only ona) Other: 4☐ Nursing Homa 5 Rasidance 6 ☐ Othar (Specify) Medical Certification: To 1 Yas 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Affer Natural 2 Accident 5 Pending invastigation n 24 hours after death. he Funeral Director: After classic filled in by the fur 1 ☐ Yas 2 ☐ No 6 Could not be detarmined within 24 hours after der To the Funeral Director completely filled in by the 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a. Certifier the state 29b. Signetura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person eted causa of death (Item 23a) (Type, Print) Ave. 31. Data filed (Month, Da) 05 20 32. Registrar's Signatura State Registrar

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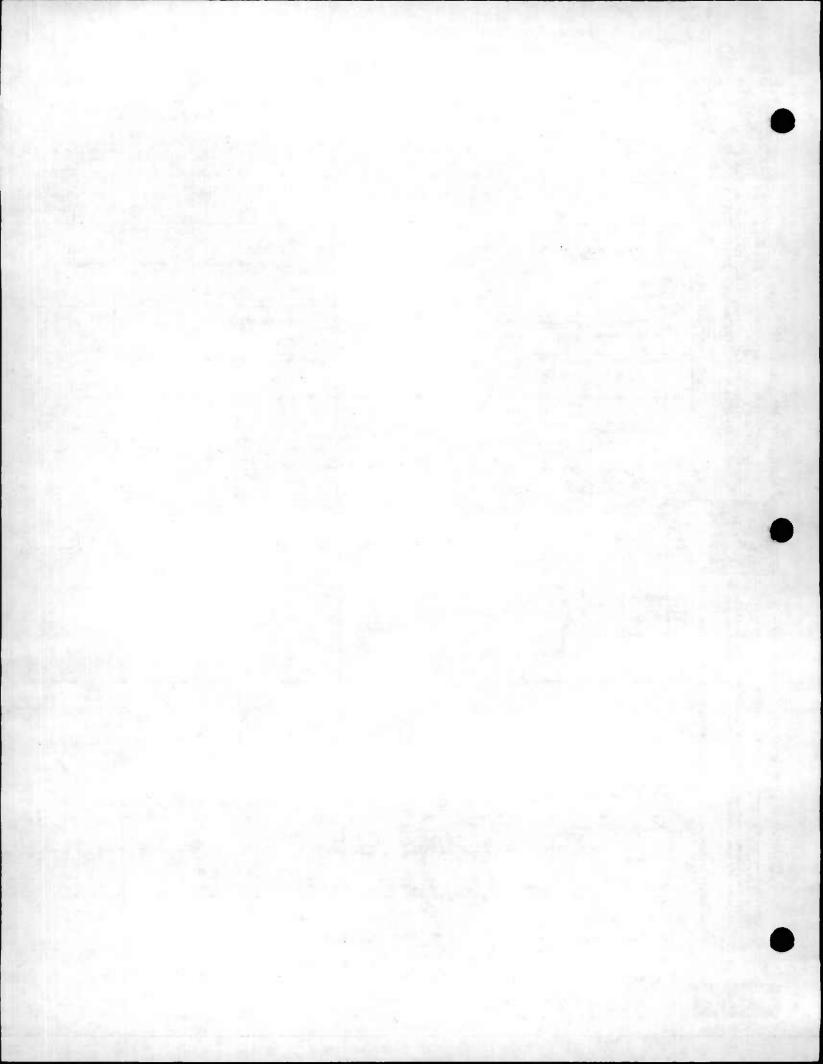
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month Veer **Physician** Joanne Andrews Mc Quade MM 2000 0415 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Stella Maris Hospice @ Mercy Hospital **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Vre Months Deys Hours Min. 5. Social Security Number Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 □ M 2 N F Yrs Director 212-36-2144 Aug. 24, 1938 Maryland Usual Residence of Decedent pernit. Pages 1 and 2 ahould be filled within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Importants if Itam 27 is marked other than "natural", or items 23s or 28s-f ahow shiplury or other traumatic event, the Medical Examinar must be notified at Page. 10a State 10b. Count 10c. City, Town or Location Od. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 603 Brookwood Road 21229 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 Never Merried 2 N Merried Saltimore, Maryland 21215-0020 1 ☐ Yes X No Specity: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Executive Assistant MD State Government 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be John James Andrews Mary Elizabeth Bock 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John E. McQuade, Jr./Husband 603 Brookwood Rd., Baltimore, MD 21229 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a, Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriat ②☐Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Laurel, Maryland 21. Signature of Edneral Service Licensee 22. Nema alide dilinas to OF icilyty Witzke Funeral Homes, Inc. 1630 Edmonston Ave. Catonsville, MD 21228 mun 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Breast Carrer Immediate Cause (Final disease or condition resulting in death) /Medical yew Examiner Due to (or es a consequence of): Physician/Medical Examiner ettending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or es e consequence of): Records, P.O. sate has been signed by the page 2 should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy periormed? 2 No 1 ☐ Yes 2 ☐ No certificate : 1 Yes Division of Vital or Attending Physicien: director, 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca (Specify) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA 1□ Yes 3E No Certification: To hospir this funeral 28d. Describe how Injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 ☑ Naturat 2 ☐ Accident aftar deeth.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No To the Hospital or Atter Within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner steted. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) N D40854 00 30. Narpe and eddress of person who completed cause of death (Item 23a) (Type, Print) Bultimore, Riseber 301 MD St 1) 21202 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State **Q** 2000 1 souks! MAY Registrar



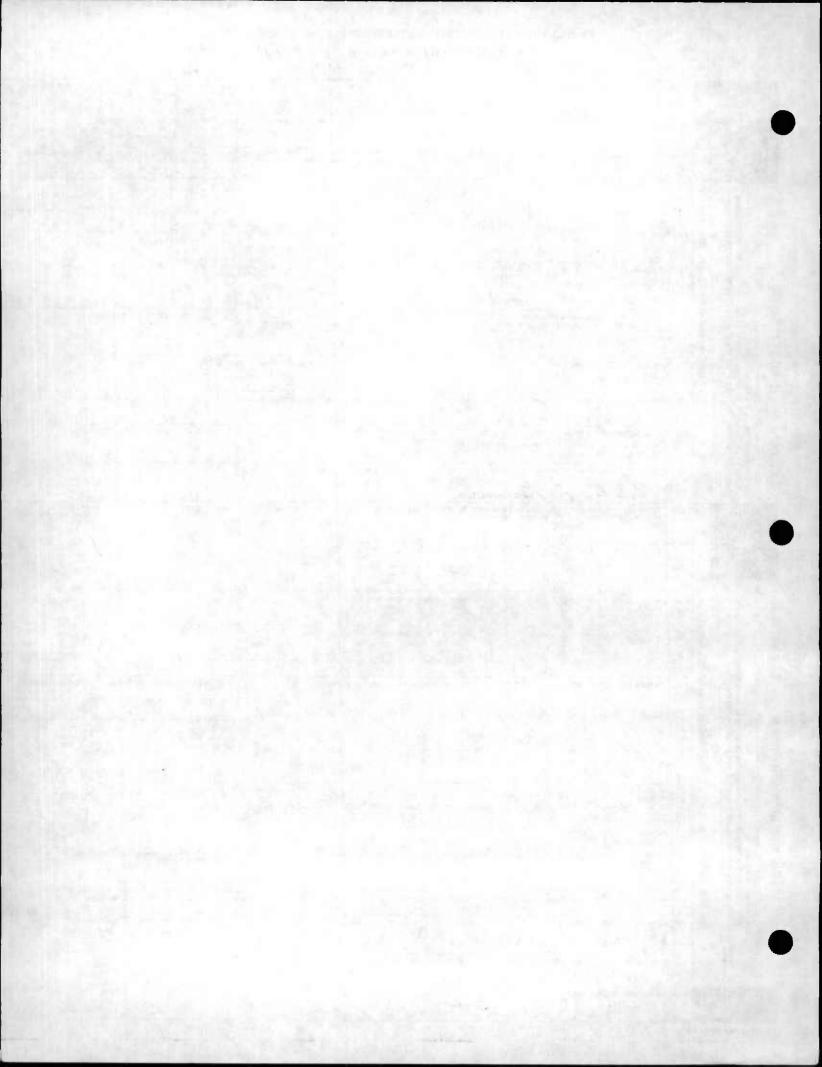
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marie Loretta McGuinness May 8,2000 12:30 pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7318 Farthest Thunder Court Columbia Howard If Under 1 Yaar If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months 1□M 2□F Director 098-16-9790 84 June 28,1915 New York Usual Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show MD Howard 1 ☐ Yes 2√☐ No **Funeral Director** Columbia 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or frema 23a or 2 eny Injury or other traumatic event, the Medical Examiner must be an ence. 10799 Hickory Ridge Road 21044 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Baitimore, Maryland 21215-0020 1□ Yes 2□ No XX Specify. 3☐Widowed 4 ☐ Divorced Specify: by Yeer or Detes White Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 Office Worker Retail 17. Father's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumame) Be Edward Fegen Sarah T. Hull 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Smith/Daughter 7318 Farthest Thunder Court, Columbia, MD 21046 20c. Location - City or Town, Stata 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete XX Buriel 2 Cremation 3 Removel from Stete Crestlawn Memorial Park 5/10 4 ☐ Donetion 5 ☐ Other (Specify) Marritoosville, MD 21. Signature of Junerel Service Licansee 22. Name and Address of Facility Witzke Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrast, shock, or heert teilure. List only one cause on each line.

5555 Twin Knolls Road, Columbia, Maryland 21045.

Approximate Approximate Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examine acute MI thet the deeth certificate be executed physicien and s the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequenca ol): Box 68760. Due to (or es e consequenca of): 80 USB Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t by The law requires 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed page 2 s 1 Yes 2 No 1 Yes 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Daughter's Other: 4 Nursing Home 5 Residence Symptham (Specify) Residence Hospitel: 1 Yes 2 No edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es stated.

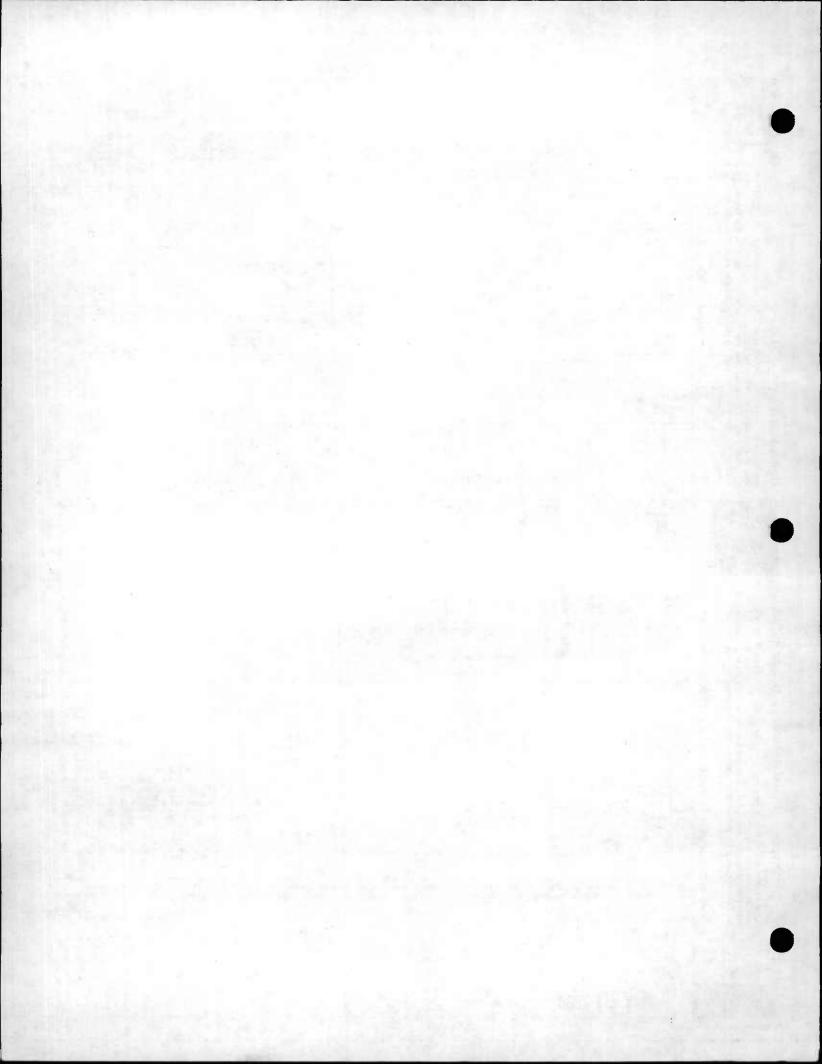
2 Medical Examiner: On the best of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D09526 00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BRUNO, Columb a, MD MP. Med Arts RANCIS 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State MAY 10 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Ryland S. Massie May 4, 2000 8:25 am /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel General Hospital Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
March 10, 1916

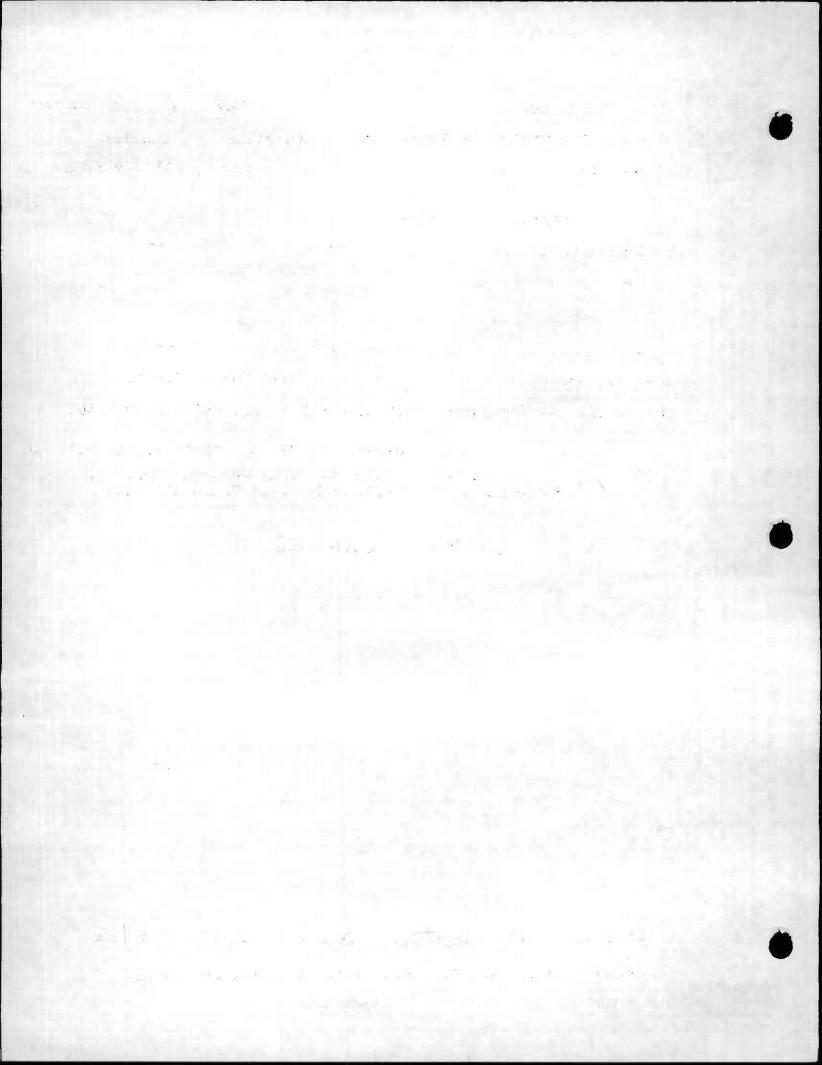
8. Birthplace (Stete Country)
Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F 226-12-7205 Vrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Madical Experience must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Severna Park 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7828 Clark Station Road 21122 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 🕅 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by White Specify: XX Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Military & Steel Worker Military 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Alanzo C. Massie Campbell Mary Agnes 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Velma Mood 334 Derby Shire Lane Riva, Maryland 21140 Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility moloso Gary L. Kaufman F.H. Meadowridge Memorial Park 7250 Washington Boulevard Elkridge, Maryland 21075 Marshall 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Due to (or as e consequence of): do Examiner Physician/Medical Examiner physician and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Due to (or as a consequence of): been signed by the s should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown Records. ģ 24b. Were autopsy findings eveilable prior to completion of causa of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital funaral director. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 25 Ho patient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 1 Devatural
2 Accident 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 6 Could not be determined 3 ☐ Suicíde 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281, Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) *Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ce 29c. License number 29d. Data signed (Month, Dev. Year) 1 vet 30. Name and address of person who co d cause of death (Item 23a) (Type, Print) A we Charles one) 2108 31. Date filed (Month, Day, Year) MAY 1 1 2000 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Yee Physician May 8 2000 5:35AM Janet Edith Mahan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Charles County Nursing Rehab Center La Plata Charles if Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Y 7. Aga (In yrs. last birthday) If Undar 1 Year Months Days 9. Birthplace (State or Foreign Country) Michigan 5. Social Security Number 6. Sex **Funeral** 1 M 2 XX Days 372-30-9842 67 May Director Usual Residence of Decedent death with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show itam 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner from be notified at 1 ☐ Yes 2 ZNo Director Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20602 USA #4 2006 Wingate Ct. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ñ No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or iten any injury or other traumetic event, the Med cel Examina 1 ☐ Navar Married 2 X Married Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 12 Retail 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Be Marie Murphy Dupont James A. Dupont 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2228 Bridle Path Dr. Waldorf, MD 20601 Cheryl Williams/Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dispesition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 5/8/00 Charlotte Hall, MD Brinsfield-Echols FH4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. M00945 23 Vac P.O. BOX 567 LA PLATA, MD 20646 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical CANCED NYL **Examiner** Due to (or as a consequence of) Examiner The law requires that the death certificete be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 98 attending p 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be datached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en autopay page 2 has 1 ☐ Yes XIXNo 1 TYas 2 TNo certificate Division of Vital or Attanding Physician: funerel director, 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: A Residence 6 Other (Specify) 1 Yes 2 Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred + DNatural 5 Pending 1 Tas 2 🗆 No 24 hours after death. Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and menner es steted. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and pieca, end due to the cause(s) and manner stated. within 2 \$ 29b. Signature and title of certifier 29c. License number 29d. Date signad (Month, Day, Year) 0 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Deneva souls MAY 0 8 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dey **Physician** Frederick Nevin Markle, Sr. April 27, 2000 1416 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Carroll County General Hospital Westminster If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Dete of Birth (Month, Dey, Year) **Funeral** Days MM 20F 215-26-0967 70 Feb 24,1930 Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23s or 28s-f show edical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4529 Lower Beckleysville Road 21074 USA death Funeral 14. Race - American Indien, 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hydjens.

Intel if Nem 27 is marked other than "natural", or its any of other thansand seven, the Medical Examines any or other thansand seven, the Medical Examines Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Micro Tel/ Elementery/Secondary (0-12) College (1-4or 5+) Electronic Engineer Adams Russell 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Monroe L. Markle Mazzie E. Warner 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia Markle, wife 4529 Lower Beckleysville Rd, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Department of Important: If It any injury or o 1 Burial 2 Cremetion 3 Removel from State 5/01 Hampstead Cemetery Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Physician/Medical Examiner 128cm 0 attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Wiknown sate has been signed by page 2 should be detac Records, Š 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ 110 1 Yes 2 1No certificate Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 1 Inpatient 2 DER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 ONetural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide **Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

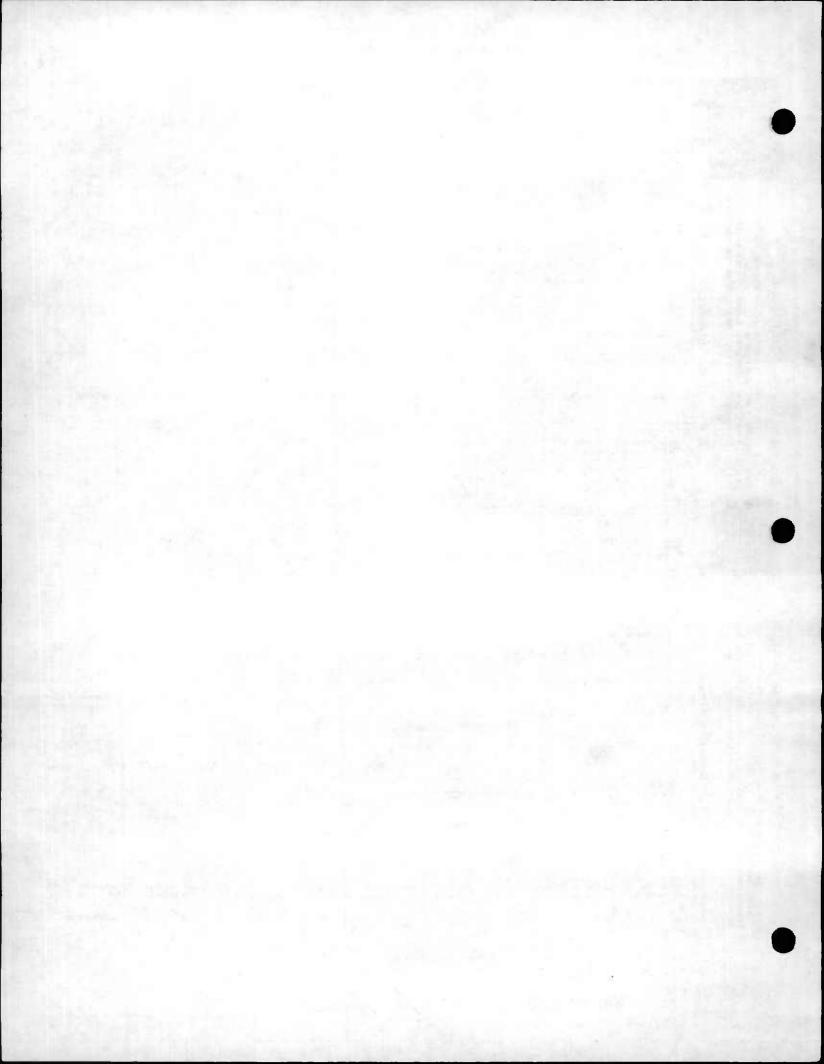
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Dey, Year) 3316 28 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) MAY 0 2 2000

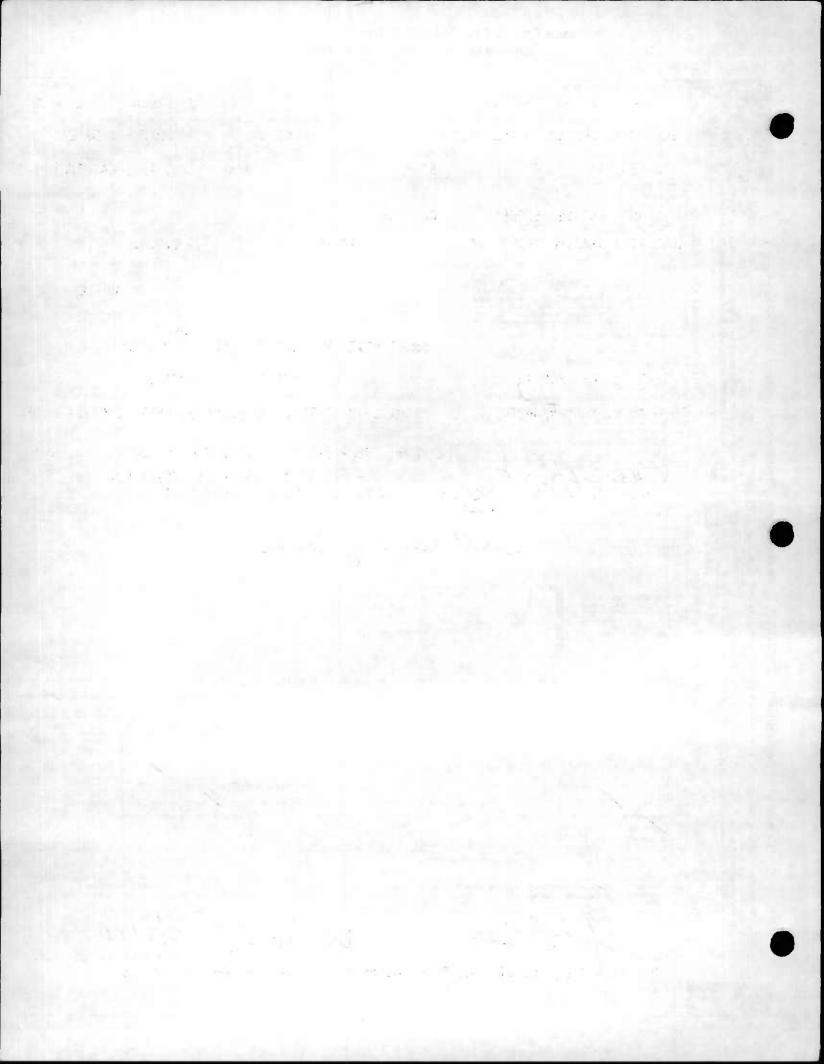
Steven Shaffer MD, 2111 Hanover Pike, Hampstead, MD 21074

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene amend item 11 per hd G784 6/27/00 yg Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth . 2000 APRIL **Physician** NATHAN GEORGE MODLIN 29, 5:00 AM /Medical 4a Facility Nama (If not institution, giva straat and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 8500 MIKE SHAPIRO DRIVE #423 CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days Hours Months 10 M 2□ F Yrs. 578-52-3686 59 JANUARY 22, 1941 WASHINGTON DC **Director** Usual Rasidance of Decedant permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylend Dependment of Haalth and Mentel Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No MARYLAND PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ä 8500 MIKE SHAPIRO DRIVE #423 20735 U.S.A. Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Reca - Amarican Indian. 11. Marital Status Bleck, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas: 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE ģ 3 ☐ Widowad 4 ₩ Dix Completed 15. Dacadent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry SELF Elemantary/Secondary (0-12) Collaga (1-4or 5+) SHEET METAL MECHANIC/WELDER **EMPLOYED** 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maldan Surname) Be NATHAN HENRY MODLIN LOUISE RUTH CURTIS P 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) DEBORAH K. KOLLAR/DAUGHTER 1401 15TH STREET, PARKERSBURG, WEST VIRGINIA 26101 20b. Placa of Disposition (Nama of camatary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 🛱 Cramation 3 ☐ Ramoval from Stata 5/03/2000 WALDORF, MARYLAND 4 Donation 5 Othar (Spec THE HUNTT CREMATORY THE HUNTT CREMATORY, POST OFFICE BOX 156, KNISLEY M01164 20604-0156 WALDORF, MARYLAND 23a. Part 1. Enter the disaasa, or complications that a unenable deeth. Do not entar the mode of dying, such as cardiac or respiratory arrast shock, or haart failure. List only one ceuse on a unit in the mode of dying, such as cardiac or respiratory arrast shock, or haart failure. Approximata Interval Batwaan Onsat and Daath Physician Small Cell Lu Immediata Causa (Final disaase or condition rasulting in death) Cancer /Medical **Examiner** Examiner attanding physician and for use es the bunal-trensit The law requires that the death certificate be executed Sequantially list conditions, if eny, laading to immadiata causa. Entar Undartying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consaquance of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequança of) Part il. Other significant conditions contributing to daath but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Onknown by 24b. Wara autopsy findings available prior to completion of causa of daath? 24e. Was an autopsy Completed performed' s certificate has 1 Tas 2 No 1 ☐ Yas 2 ☐ No Division of Vital After this certification of the funeral director, or Attending Physician: Be 25. Was casa referred to medical 26. Plece of Death (Check only ona) axaminar? Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Residanca 6 ☐ Othar (Specify) 1 Yas 2 1 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manne of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Day Yaar) 1 Neturel 5 Panding investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Al complately filled in by tha fu death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the causa(s) and mannar es steted. 29e. Cartifiar Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(s) and manner stated. 29b. Signature and title of berti 29c. Licanse number 29d. Day signed (Month, Day, Year) 00 3800 Reservoir Road, N.W. 30. Name and address of parson who complated causa of death (Itam 23a) (Type, Print) JOHN MARSHALL, MD, Vincent T. Lombardi Cancer Center, Washington, DC 31. Data filed (Month, Day, Year) 32. Registrer's Signature State 0 5 2000 reser

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Year O'Donnell **Physician** Teresa Agnes April 4b. City, Town, or Location of Death 30 2000 1:30 P.M. /Medical 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Carroll Westminster Summerville at Westminster If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 19 1905 Birthpleca (State or Foreign Country) Md 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2₹7F 94 217-18-1010 Yrs. Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville Md 1 ☐ Yes 2 ☐ No Director or 28n-f 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21784 6501 Oakland Mills Road Herne 23a Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 11. Marital Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married natural, or 1 ☐ Yes 2 XNo Specify: Specifywhite 3℃ Widowed 4 Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) school teacher education Department of Meath and Zehould be file Department of Meath and Mental Hyg Important: If New 27 is merked other any Injury or other treatments and BASE. 17. Fether's Neme (First, Middle, Last) William Kimbal Fuller 18. Mother's Name (First, Middle, Maiden Sumeme) Edna Mae Zimmisch 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6108 Old Bartholow Rd., Eldersburg, Md 21784 Kathleen Tallent (daughter) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 5/4/00 Sykesville, Md Lake View Memorial Park 22. Name and Address of Fecility 21. Signature of Funerel Servica Licensee Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784 23a. Part I. Enter he disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Causa (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequenca of): Examiner attending physician and for use as the bunel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): Physician/Medical Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No signed b É 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 190 Certification: To 28c. Injury et Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Panding investigation 1. Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760 P.0. Records, Division of Vital ospital or Attending Physician: hours after deeth. uneral Director: After this certifics by filled in by the funeral director, i within 24 hours aft To the Funeral Di completely filled in

Baltimore, Maryland 21215-0020

filed within

State Registrar

edical

29a. Certifier

29b. Signetyre end title of certified

Dey, Year)

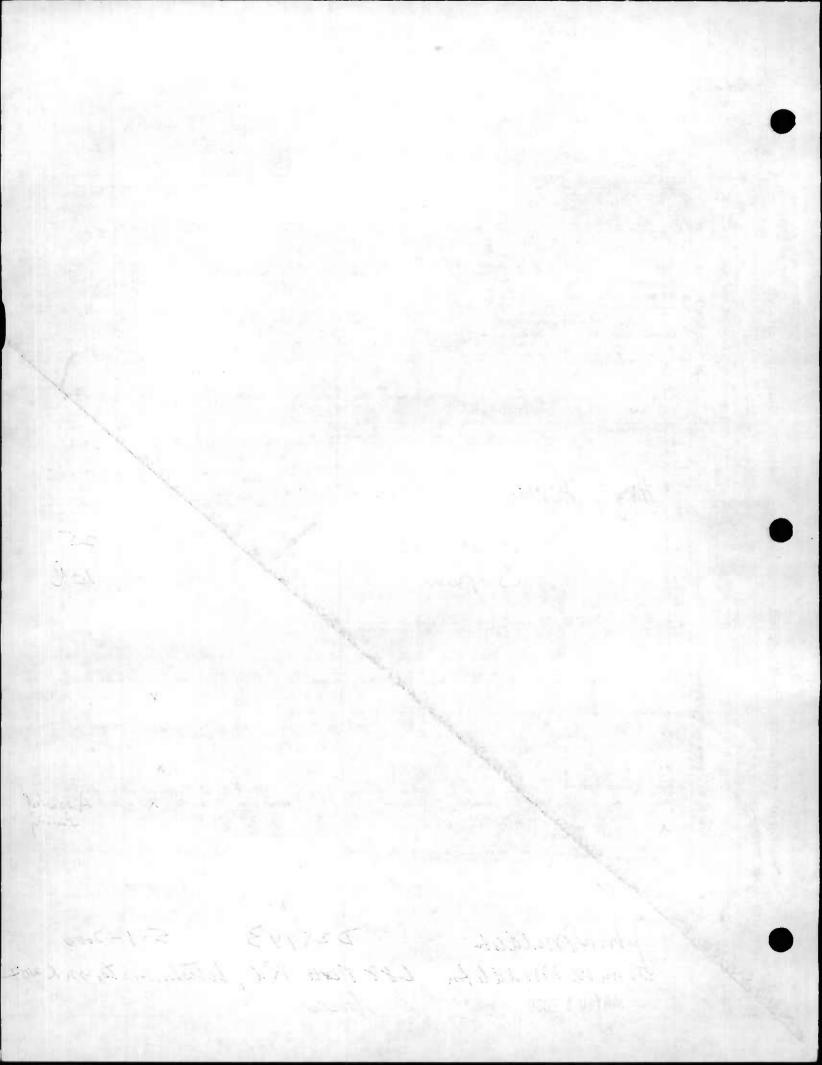
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29c. License number

1 New York Itying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

30. Neme old eddress of person who completed ceuse of death (Item 23a) (Type, Print)

Rd Wrotminster m & 2007



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** OLIVIA BARTLETT PRICE 2000 April 20 1015am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital @ Easton Easton, Maryland Talbot If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth
Months | Days | Hours | Min. | 10-27-1902 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foraign **Funeral** 1□M 20 F 218-05-0446 97 MARYLAND Yrs. Director Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 √Yas 2 No Director MD TALBOT TRAPPE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? free mast be n 29160 KRISMORE COURT 21673 death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after c Important of Health and Mental Hyglens. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Exercises DRGs. 1 Never Married 2 Married Specify: WHITE Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL BUS DRIVER EDUCATION 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 WALTER H. BARTLETT EMMA GERTRUDE WELSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) RAYMOND T. SANDERS/EST. PERS. REP. 29160 KRISMORE COURT, TRAPPE, MD 21673 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Olivia 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata SPRING HILL CEMETERY 4-25-00 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA onam 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onset and Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The lew requires that the death certificate be executed for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue P.O. Box 68760. Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yea 2 No 3 Probably 4 Unknown Records, Be Completed by page 2 should be 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? peen : completion of cause of death? 2 200 this certificate 1 Yas 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physicien: To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was casa refarred to medical 26. Placa of Death (Check only one) 1 Yas 2 No Other: Medical Certification: To 1 Inpatient Nursing Homa 5 Rasidence 6 Othar (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

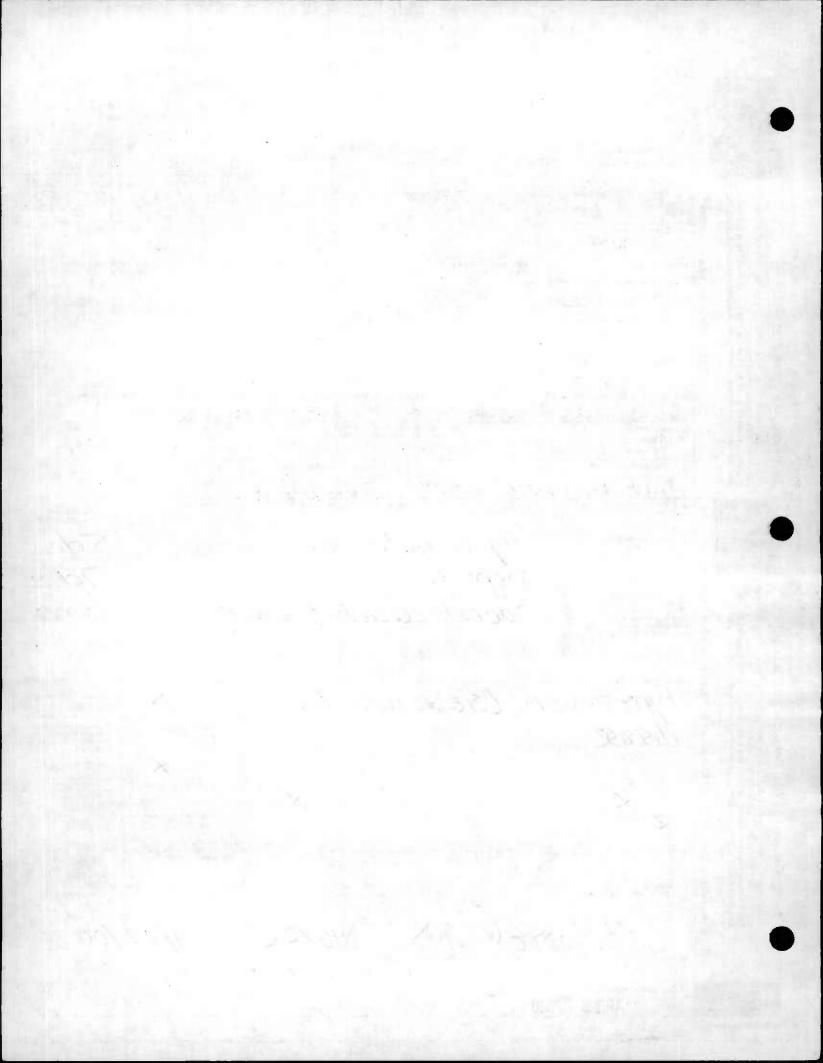
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) on 41100 and address of person who completed cause of death (Item 23a) (Type, Print) HOLLYWOOD, JENNIFER, M.D. 607 DUTCHMANS LANE EASTON, MARYLAND 21601 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

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Registrar

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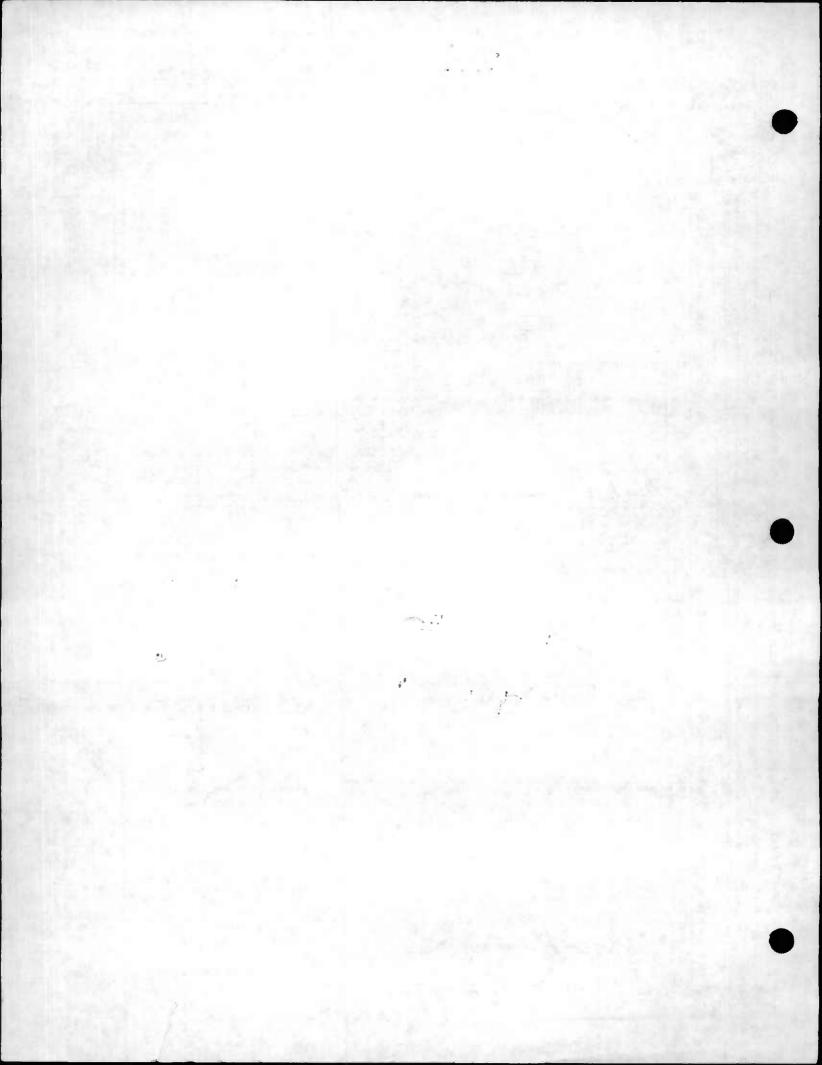


State of Maryland / Department of Health and Mental Hygiene 15729

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ician	1. Decedent's Nama (First, Middle, Las	st)					2. Data of Dear Month	Dav	Yaar	Tima of Death
dical	John	Potter	Jr.				April	L 25		629
niner	4e Facility Nama (If not institution, give					4b. City, Town, or l		4c. County		
	The Memorial	-		todays) If Und	er 1 Year	Easton		Talb		(C)
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	10a. Stata 10b. County		10c. City, Town	or Location					10d. In	sida City Limits
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3	10e. Street and Number				ip Code		1	0g. Citizen of V		
Luinara	54 Jowite	Street		2.	1601			U.S.	•	
	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Marital Status 14. Was Decedent Ever in U,S. Armed Forces? 15. Was Decedent Ever in U,S. Armed Forces? 16. Was Decedent Ever in U,S. Armed Forces? 16. Was Decedent Ever in U,S. Armed Forces?			If Yas, sp	edent of F secify Cub 2 No	dispante Origin? (S an, Mexican, Puert Specify:	pecify Yas or No- o Rican, atc.)	No- 14. Raca - Amarican Indian, Black, Whita, atc. Specify: Black		
	15. Decedent's Ed	ucation	16a.	Decedent's Us	ual Occup	pation		16b. Kind of Bu	usinass/Industry	
	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5		(Give kind of w life. DO NOT	vork done use retire	during most of word)	king			
	Elementally/Secondary (0-12)	10	**	Proo	f- P	ress		Prin	ting	
	17. Father's Nama (First, Middle, Last)					18. Mother's Nan	na (First, Middle, I	Ma <i>ide</i> n Surnan	ne)	
2	John Potter					Mar	y Hunt			
	19a. Informant's Name/Ralationship (7	ype, Print)		_		and Number or Ru				
	Phyllis Potter	•	5	4 Jo	wite	Street	East	on, Ma	. 2160	7
	20a. Mathod of Disposition 1 M Burial 2 Cremation 3	Domovel from State	20b. Place of cemeters	Disposition (N y, crematory or	lame of r other pla	ce)	Data	20c. Location -	City or Town, S	tata
J	4 Donation 5 Other (Specify		Ri	chard	son	Mem Par	k 5/1/2000	Easto	n, Md.	
by Physician/Medical Examiner	23a. Part1. Enter the disease or compshock, or heart failure. List only of the second	a. Contributing to death be	Dua to (or as a co	consequence of the underlying	n): n): n):	FAREN	23b. Did to	obacco use co as 2□ No	Initian Onse	4 Unkno
Completed	5-684						24a. Was a perform		available	ion of causa
5							1 🗆 Y	as 2 No	1 ☐ Yas	2□ No
90	25. Was case refarred to medical examiner?					26. Place of Dea	th (Check only or	na)		
0	1 Yas 2 No	Hospital: 1 ☐ Inpatie	nt 20 ER/Out	patient 3 l	DOA OI	her: 4 Nursing H	oma 5□ Rasid	enca 8 🗆 Oth	nar (Specify)	
Certification:	27. Mannar of Death 1. Natural 5 Pending (Month, Day) 2 Accident Investigation		y Year) 28b. T	Injury Work? M 1 ☐ Yas 2 ☐ No ma, farm, street, factory, office 28			28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Certific	3 Suicide 6 Could not be detarmined	iry - At homa, far :: (Specify)								
	29a. Certifier 12 Certifying Phy	rsician: To the best of	axamination and	death occurre Vor invastigation	d at the ti	ma, data and place opinion, daath occu	, and dua to tha c rred at tha tima, d	ausa(s) and ma ata and placa,	annar as stated. and dua to tha c	causa(s)
dical	(Check only 2 Medical Exam	and manner sta	teu.							
Medical	(Check only 2 Medical Examone) 29b. Signature and titla of certifier	and manner sta		2	9c. Licens	se number			d (Month, Day,	Year)
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Medical	ane)	and manner sta	2,	Type, Print)	D		-2 0	04.26	,-00	1d 21

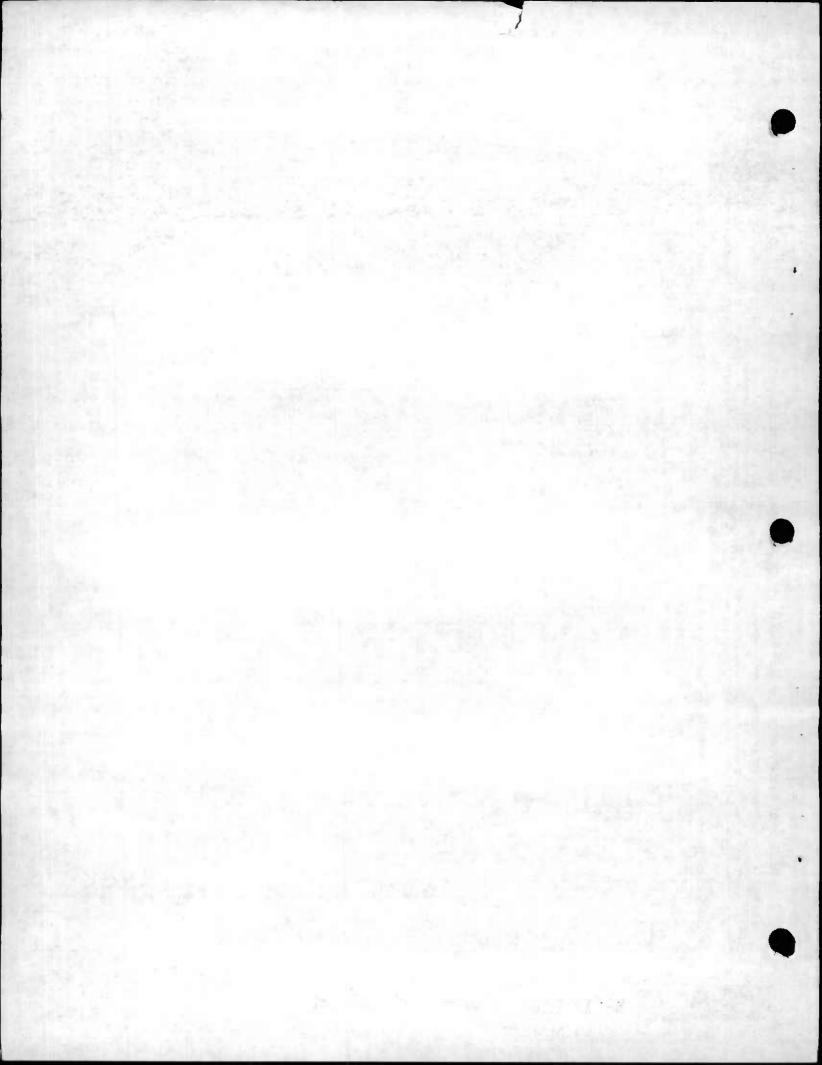
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	1. Decedent's Name (First, Middle	, Last)	ER MEO		rtificate				2. Date of De			3. Time of Deeth
Physician /Medical	Eleanor	L.	Perr	У					April	22, 200	O Year	2130 pm
Examiner	4a Facility Neme (If not institution Peninsula Reg.						Sali	sbu	-	Wico	mico	
Funeral Director	5. Sociel Security Number 222-32-1907 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🗗 F	53	last birthday) Yrs.	If Under 1 Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Nov.	rth ay, Year) 6,1946	9. Birthp Cour Wi	place (State or Foreign http) lmington,
r 28e-f show inothest at irector	10a. State 10b. County 10c. City, Town or Location									1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No	
iner matte nother	10e. Street and Number									10g. Citizen of \		ntry?
neral	816 S. Schu	12. Was Deced	lent Ever in U				_804 Hispenic Origin? (Specify Yes or N			U :	en Indian,	
by	1 Never Merried 2 Marr 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dat	2 ☐YNo		Was Decedent of Hispenic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. □ Yes 2 No Specify:				Hican, etc.)	Specify		hite
r, me water	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Tele Pro				tking 16b. Kind of Business. Corporations Inc.			e Express
Be	17. Fether's Name (First, Middle,				0.6					, Maiden Surnan		
10	William Per 19a. Informant's Name/Relations	-		19h Maill	na Address	(Street				Kibles ber, City or Town,		Code)
	Kimberly A.		ki		53 S.	•						DE 19720
and to the	20e. Method of Disposition 1 Burial 2 Cremetion 4 Donetion 5 Other (S)	3 □Removel from S	20b. F	Place of Disponentery, cremetery, cremetery	metory or off	her plac		rk	Dete 1/28/2	20c. Location -		own, Stata astle, DE
Important: If item 27 is marked other eny injury or other traumatic event, pncs. To Be C	21. Signature of Fulleral Service Muse My Or	Reslile "	88500							Funera		omes, Inc
ysician Medical aminer	23a. Pert1. Enter the disease, or shock, or heert feilure. List Immediate Cause (Final disease or condition resulting in death)	a	CARDI	AC ARR	HYTHM:	IA		Darone	от гозряваюту с			Approximete Intervel Between Onset and Death
ed by the attending physician and deteched for use es the burial-trensit Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last	c	Due to (c	r es e consec	quence of):							
d by the atterected for Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SCHIZOPHRENIA								23b. Did tobecco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Onknown			
2 should be pleted by									24a. We	s an autopsy formed?	00	ere eutopsy findings allable prior to impletion of cause death?
certificate h rector, page	***								1.5	Yes 2□No	11	☐ Yes 2☐ No
his certificate he if director, page	25. Was case referred to medical examiner? ★GYes 2 No	Hospital: 1 ☐ fo	nationt 210	FR/Outnatie	nt 3 DO	Oth	ner:		th (Check only	one) sidence 6 □Ott	ner (Sneci	(v)
2 5	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	28e. Date of (Month)	28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?						28d. Describe how injury occurred			
in by	3 ☐ Suicide 6 ☐ Could determ	not be Ined 28e. Plece of building	of Injury - At high	ome, farm, st	reet, factory,	office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
nin 24 hours s un Funerel D indietely filled Medical Ce	(Check only 2 Medical one)	g Physician: To the b Examiner: On the bas end manne	sis of examine		vestigation,	in my o	ppinlon, dea			, date end plece,	end due t	o the cause(s)
5 T 2	29b. Signature and title of certifie	. 1/					se number		29d. Date signed (Month, Day, Year) April 23, 2000			
19	Mints - O	0 1/			-		M.E.			Am2-1) 3 .	000

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death MAYONTS, 2000 23:11 PM RAVEN **Physician** KERR FNE /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HGNES ALTIMORE If Under 24 Hrs. 5. Social Security Number If Undar 1 Yaar 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) 9. Birthplaca (Stata or Foraign **Funeral** 1□ M 200F Days Hours Months 15 208-16-0842 Director Usual Rasidance of Decedant Pages 1 end 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental hygiene.

Mrt. If them 27 Is marked other than "natural", or items 23s or 28s-f ahow unty of other traumatic event, the Medical Exams or must be notified at uny or other traumatic event, the Medical Exams or must be notified at 10a. Sfata 10d. Insida City Limits 10b. County 10c. City, Town or Location CATONSVILLE 1 ☐ Yas 2 No BAUTMORE Funeral Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yas or No-tif Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S Armed Forcas? 11. Marital Status 1 Tas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1□ Yas 2 No 21215-0020 Specify. Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Indus O'COHNOR, Elamantary/Secondary (0-12) Collega (1-4or 5+) STATE GENT AND FUNN Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) 19b. Mailing Address (Street and Number or Rulal Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type Department of Health er Important: If Item 27 Ia any Injury or other trau 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata
4 Donation 5 Othar (Specify) re of Funeral Service Licer 22. Nama and Addrass of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Daath **Physician** /Medical Immediata Causa (Finat disaasa or condition rasulting In daath) · RUPTURED ABDOMINAL AORTIC ANEURYSM Examiner Dua to (or as a consaquanca of): Physician/Medical Examiner The lew requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last igned by the attending physician end be detached for use as the buriel-tran Dua to (or as a consequence of): Dua to (or as a consaquanca of): P.O. Part tf. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown obstructive pulmonary disease þ of Vital Records, 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy performed? Be Completed certificate has 1 Yas 2 No 1 Yas 2 No Director: After this certifical in by the funeral director. 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred or Attending 1 DNatural 5 Pending Invastigation fnjury 1 Yas 2 No death. 2 Accidant 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral D 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifian 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number Shyles m.D D226 Y8 MAY 8, 2000 10 and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Jerome T. Snyder, m.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

MAY 10 2000 Denue B. Anall 31. Data filed (Month, Day, Year) State MAY 10

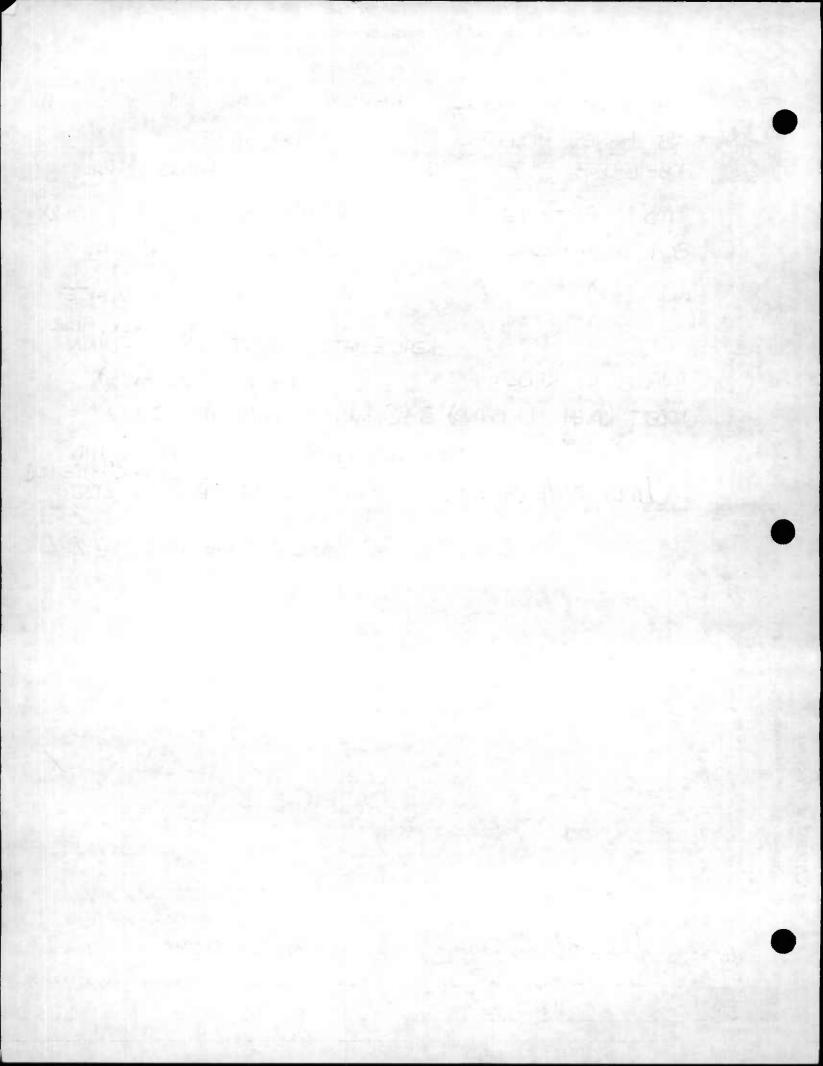
DHMH 16 Rev 6/95

Registrar

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RAVEN, PHYLENE

2000



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Virginia 2000 Yaar Carpenter Reed 6:45am 2 May /Medical 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Daath **Examiner** Fairhaven Sykesville Carroll If Undar 24 Hrs. If Under 1 Yaer 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Dey, Year) **Funeral** Birthplaca (Stete or Foreign Country) Months Days Hours 196-28-9295 1 □ M 2 1 F Director Jan 6 1904 Md Usual Rasidence of Decedant the Merylend permit. Pages 1 and 2 should be filled within 72 hours efter death with the Marylan. Department of Heelih and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examinet must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Carroll Sykesville 1 XYes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 7200 Third Avenue 21784 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, White, atc. 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: 1 Nevar Merried 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: white þ 3 □ Widowad 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coliaga (1-4or 5+) secretary clerical 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumeme) Edward Norman Carpenter Virginia Dolly 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Margaret McPherson (daughter) 6005 Cedar Ct., Sykesville, Md 21784 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Surial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) Christ Church Cemetery 5-4-2000 Accokeek, Md 22. Nama and Addrass of Facility 21. Signature of Funeral Sarvica Licansee Haight Funeral Home & Chapel ▶ Page Staight Sterburt P.O. Box 195 Sykesville, Md 21784 23a. Part1. Entar the diseasa, or complications that causad the death. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batwean Onset and Deeth **Physician** Immediata Causa (Finel disaese or condition rasulting in death) /Medicai anorexia weeks Examiner Dua to (or as a consequence of): Examiner depression yeurs ettending physiclan end for use es the buriel-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): arebrovascular disease Records, P.O. Box 68760, yeurs death certificete be Iclan/Medical thet initiated avants rasulting in daath) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Physic 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of causa of daeth? Completed 24a. Was an autopsy performed? certificate hes 1 ☐ Yas 2 No 1 ☐ Yas 2 1 No Division of Vital Be 25. Was casa rafarred to medical 26. Piaca of Deeth (Check only one) Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 Nursing Homa 5 □ Rasidenca 6 □ Othar (Specify) 2 1 Yes 2 No After this funeral 27. Menner of Death 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funera 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicida 1 Certifying Phyalcian: To tha best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner es steted.

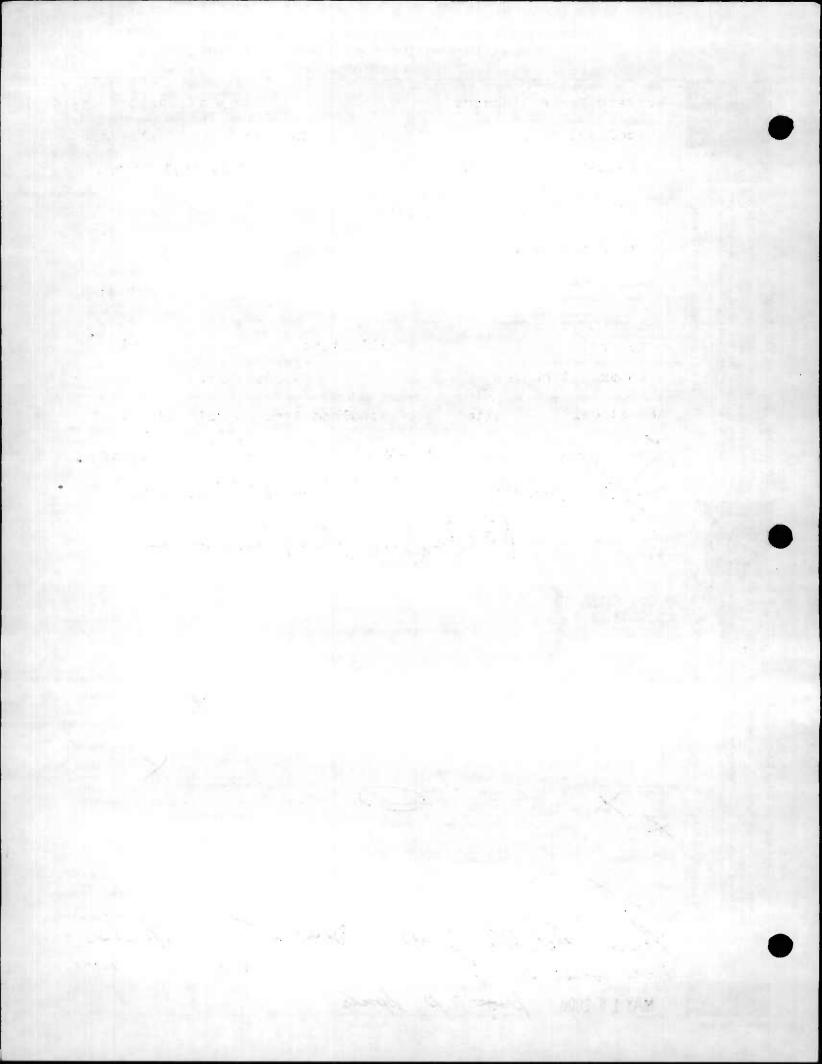
2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, death occurred et the time, dete end place, and due to the causa(a) and manner stated. 29e, Certifier Medical 29b. Signatura and titla of certifier 29c. Licensa number 29d. Date signed (Month, Dev. Year) eni C. Com MD May 2, D34406 30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print) Richmond P. Allan, MU, 1645 Liberty Rd., Elderstorg, MD 21789 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Deneva MAY 03 2000

Registrar

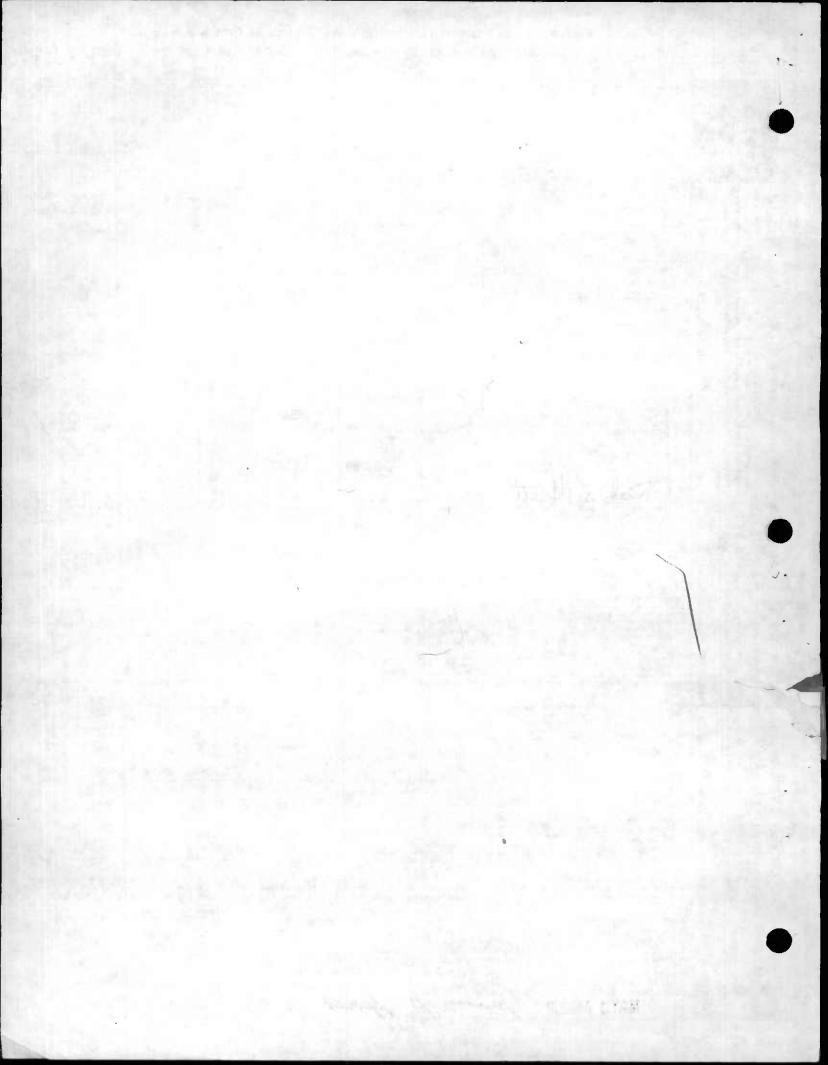
Trapelate months watch

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ore,	s 1 an f Heal f Heal other	20e. Method of Disposition		20b. Piece o	f Disposition (Neme of ry, cremetory or other p	lece)	Date	20c. Location -	City or Town, State		
Page	nant of I int: If Ite	1 Burial 2 Cremetion 3 C 4 Donetion 5 Other (Special	JRemovel from Stete (y)		Lawn Cem.		May 15	' Balti	more		
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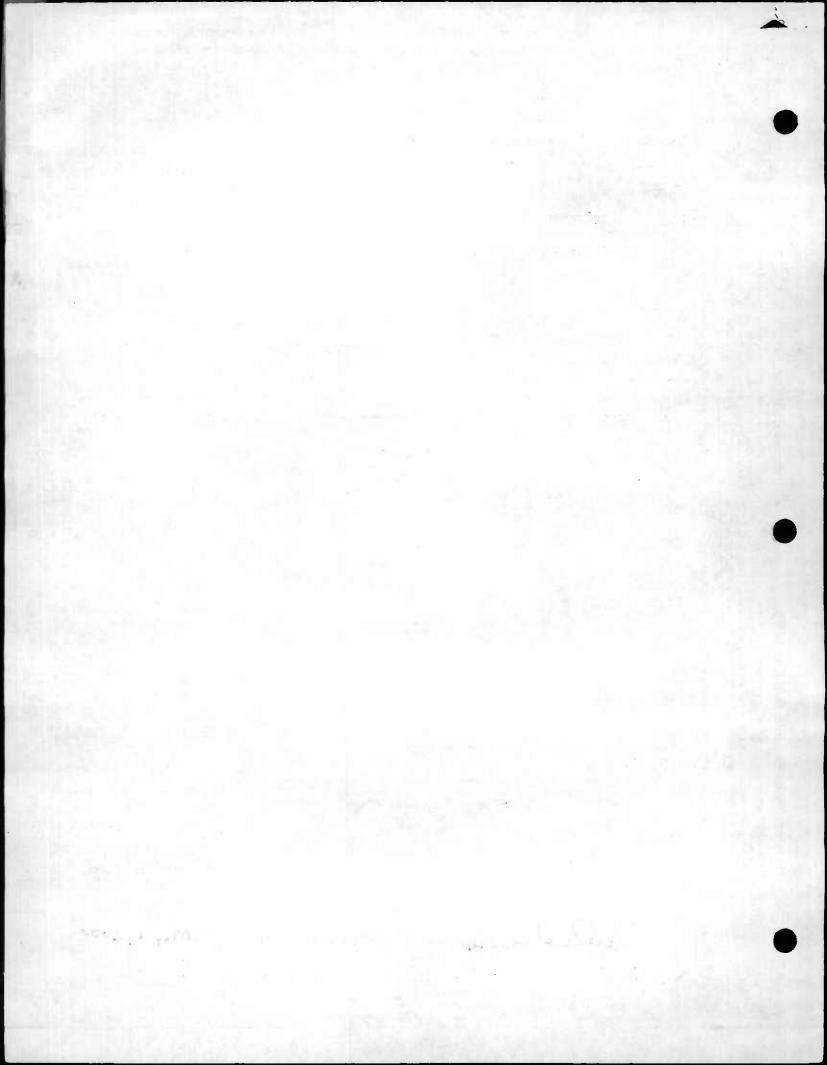


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	e (If not institution,		u <i>mber)</i>			4b. City, Tow			4c. County	y of Death	
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215-20-		1□ M 2\ F	74	Van	Months De	ys Hours	Min. (Dete of Birth Month, Des EB 26	y, Year) 1926	MARY	leca (Stete or For try) LAND
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10e. Streef and	Number				10f. Zip Cod	0			10g. Citizen of	Whet Coun	try?
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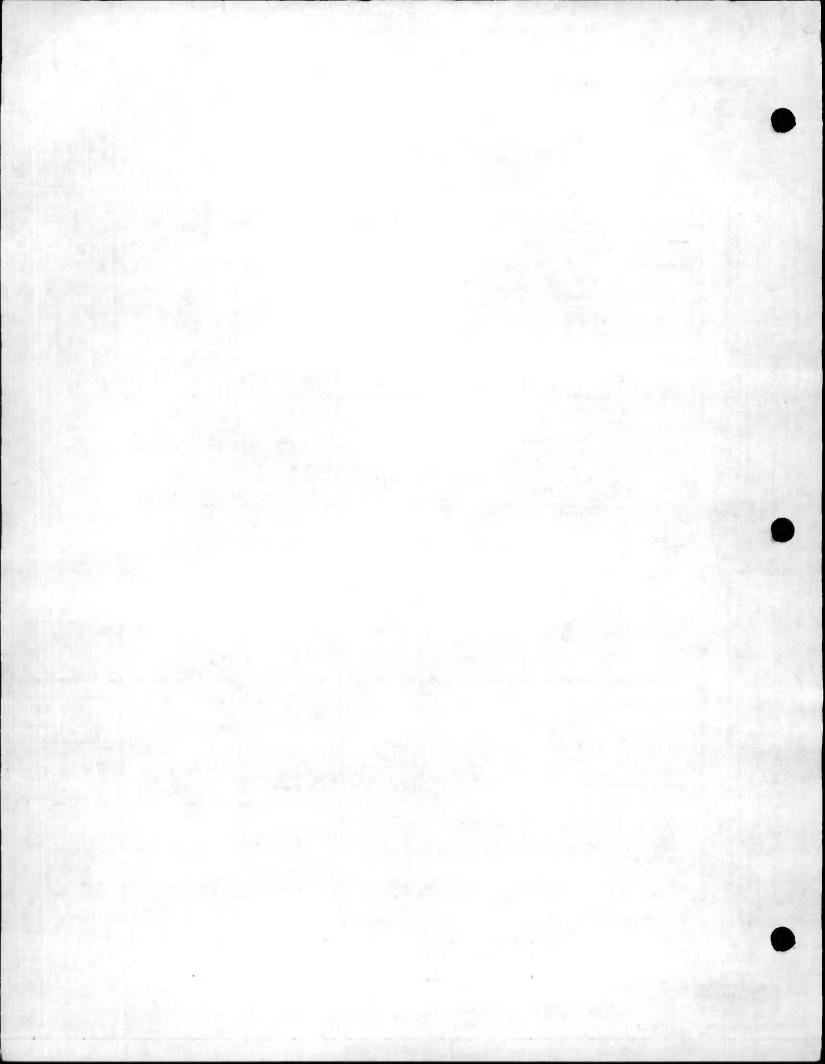
DHMH 16 Rev 6/95

Registrar



	1. Decedent S Ivan	ne (First, Middle, Las	st)						2. Data of De	eath		3. Tima of Death
Physician	Evelyn	Shapoka	S						Month May 2,	Day	Year	4:50 am
/Medical Examiner		(If not institution, give		ber)			- 1	4b. City, Town, or L			of Death	
	Sun Va	lley Nurs	ing Home					Baltimon		N/A		
Funeral Director	5. Sociat Security P 216-03-2	2832	ex □ M Ž(X)F	7. Age (In yrs 84	: last birthday Yrs.	/) If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. Oct.	rth ay, Year) 22, 1915	9. Birtho	olace (Stata or Foraig otry) yland
pue/	Usual Rasidence of 10a. Stata	10b. County		10c. C	ity, Town or L	ocation					1	0d. tnside City Limit
deeth with the Maryland ms 23s or 28s-f show crount be notified at neral Director	MD	Baltim	nore	В	altimo	re						1 Yas 2 N
or 28 or 28	10e. Street and Nu	mber				10f. Zi	p Code			10g. Citizen of	What Cour	ntry?
th will	2300 Du	laney Val	ley Roa	d			211	.33		U.S.	Α.	
5 2 5	11. Marital Status 1 □ Nevar Mari 3 ☑ Widowed	ried 2 Married	12. Was Deced Armed Ford 1 Yas 2 If Yes, Give Year or Da	ces? 2 ∆No	U,S. 13.	Was Dece If Yes, spe 1 Yes		lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yas or No Rican, atc.)	o- 14. Rad Bla Specif	ce - Amaric ck, Whita, y: Wh:	
Baltimore, Maryland 21215-0020 semit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Examination. To Be Completed by Fu	(Special Special 15. Decedent's Ed city only highest grad ondary (0-12)	ucation de completed) College (1-	4or 5+)	(Giv	DO NOT L	ork done	during most of work	king	16b. Kind of B			
Ind 2 be filed tal Hygid d other event, the	17. Father's Nama	(First, Middle, Last)						18. Mother's Nam	na (First, Middle			50010
ylan Suid be Mental Men	Fred Cr	auf						Emma Tay	ylor			
Baltimore, Maryland 2 permit. Peges 1 and 2 should be filed Department of Health and Mental hyg important: if item 27 is marked other eny injury or other traumatic event, ance. To Be C		ame/Relationship <i>(T</i> ertitta	ype, Print)					and Number or Ru				
Peges 1 - Peges		position Cremation 3 5 Other (Specify		tata	Place of Disp cometery, crit Cedar	ematory or	other plac		Data /9/2000	20c. Location Glen 1		
Balt Pemit. Departr Importa eny inje	21. Signature of Fe	unarat Service Licen	lael!	2010	77 G	ary L	. Kaı	ss of Facility	Meado	wridge	Memor	ial Park
C8760, fleate be executed fleate be executed white fleate be executed Examiner as the burial-transit edical Examiner	Immediate Causa diseasa or condition resulting in death) Sequentially list confirm, leading to incause. Enter Unde Cause (Disease or	on .	a. COLC		CER or as a conse		W				1 1 2 1 2 1 3 1 1 1 1	
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Or VIta Physician: this certific ral director,	25. Was casa refar examiner? 1 Yas 2 X		Hospitat:	200000 ==	Jenna		Oth	26. Place of Dea			GRI LINGO	HOCDIC
DIVISION OF VITAL HE To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	27. Manner of Deat 1 X Natural 2 Accident	110	28a. Data of (Month)		28b. Time of Injury		28c. Injun Wor	4 LI Nursing H		how injury occur		y) HOSPIC
DIVISION (Ital or Attanding P Its after death. e) Director: After t ied in by the funerr Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	289. Place o	f Injury - At h j, etc. (Speci	nome, farm, si	treet, factor	y, office			(Street and Num wn, Stata)	ber or Rure	al Routa Number,
he Hospital in 24 hours he Funeral pietely filled	29a. Certifier (Check only one)	Certifying Phy 2 Medical Exam	rsician: To tha b iner: On the bas and manne	is of axamina	owledge, dear ation end/or in	th occurred nvestigation	et the tin , in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and dua to	tated. tha cause(s)
To the compie	29b. Signatura and		72			29		372 (29d. Data signe	d (Month.	
						-	1	0,01		3 (41	
3	30. Nama and addr	ess of person who c	ompleted cause	of death (Ite	m 23a) (Type	, Print)						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death 30 To Year A pri Catherine Stair Anna 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Carroll 14850 Westminst Connt Carroll 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 □ M 2 🖺 F 215-26-1255 Mar 26. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ty⊟yes 2 No Maryland Carroll Manchester 10g. Citizen of What Country? 10e. Street and Number 3242 Main St. Apt. 1 21102 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes ZNo If Yes, Give Yeer or Detes: 1 Never Married 25 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Howard Esworthy Margaret Helen Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3242 Main St. #1 Manchester, MD 21102 ace of Disposition (Name of Date 20c. Location - City or Town, State Gerald L. Stair (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cem 5-3-00 Pleasant Valley, MD 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licenses 412 Washington Rd. Westminster, MD 21157 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disaasa or condition resulting in death) war Heart Disease Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Obstructive 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2000 1 Yes 2 No 1 Yes 25. Was casa reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Supatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Nems 23a or 28a-f shoy

ntal Hygiene.

ed other then "natural", or frem
event, to a model Exercise.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event, 8028.

filed within 72 hours efter

21215-0020

Baltimore, Maryland

Funeral

Completed

8

Examin Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or injury Physician/Medical that initiated events resulting in death) Last

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. hronic

1 Yes 25 No 27. Manner of Death 5 Pending

28a. Date of tnjury (Month, Day Year) investigation 6 Could not be determined

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

E.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Ave, Westmanster, MD 21157

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

Completed by

Be

To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certific

m1)

29c. License number

29d. Date signed (Month, Day, Year) 006 April 30th, 2000

ROAIT

32. Registrar's Signature

200

memoris

Registrar DHMH 16 Ray 6/95

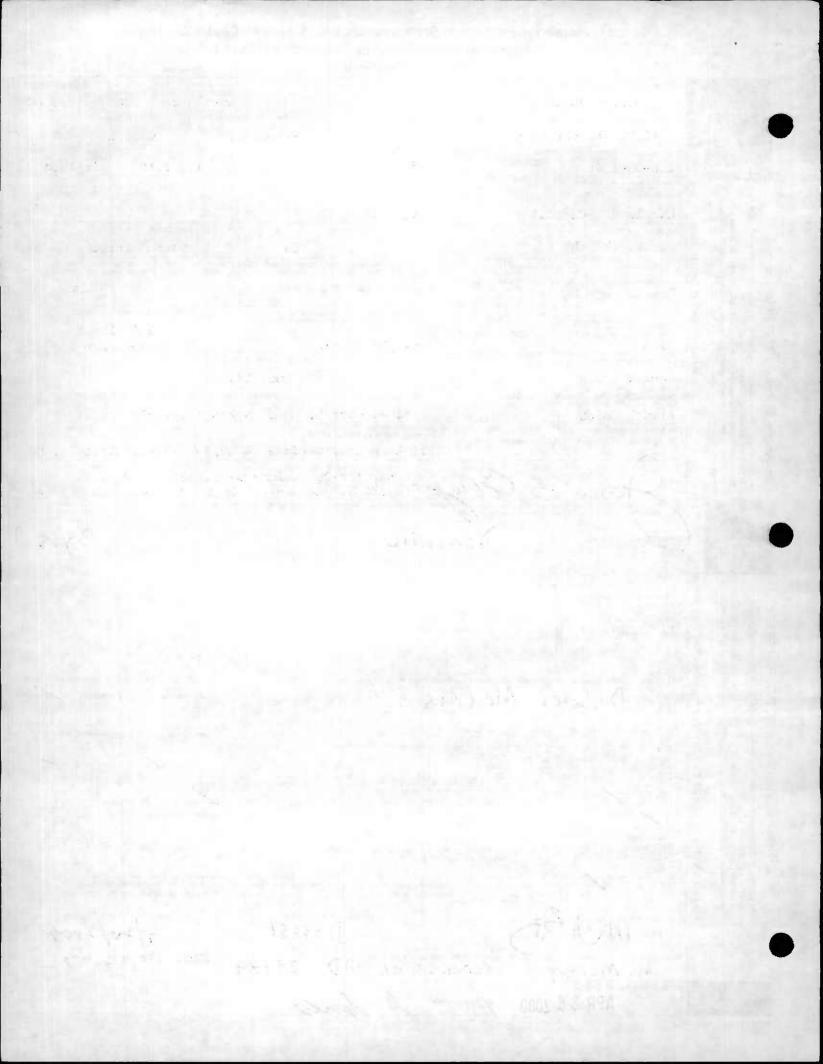
To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Division of Vital Attending Physician:

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 15739

					Certific	cate of	Death		Reg. No.	10	
	Discolution	1. Decedent'a Neme (First, Middle, L	ast)					2. Dete of De Month	eath Day	Yeer	3. Time of Death
	Physician /Medical	Walker Smith	1 2 1 4 4	174				April	26	2000	7:30 AM
	Examiner	4e Facility Name (If not Institution, g.						or Location of Deat			
		11 W. Obrecht		d 1 1154	4 1 16 1 16	nder 1 Yeer		ville		rroll	
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	and and	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
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	vith the Mar or 28s-1 s be notified Director	10e. Street and Number				. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c	11 W. Obrecht F	load				21784		United	Stat	es
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Maryland 21215-0020	by Fr.	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ if Yes, Give Yeer or Detes:	No			Specify:		Specif	* **	nite
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ary	2 should be and Mental is marked o surnatic ever	19e. Informant's Name/Reletionship	(Type, Print)	19b.	Mailing Add	dress (Stree		Rural Routa Numb	par, City or Town	, Stata, Zip	Code)
	i and 2 Health a tem 27 is other trai	Blanch Smith	Wife	1	1 W.	Obrec:	ht Road	Sykesvi	lle, MD	21	784
ore,	ges 1 and t of Health If Item 27 or other to	20a. Method of Disposition	70	20b. Place of cematary				Dete	20c. Location	- City or To	own, Stete
iii d	2 = ± >	1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec					Gardens	4/29/20	00 Marri	iotts	ville, MD
Baltimore,	permit. Par Department Important: any injury	21. Senature of Funeral Service Lice	ensee				ess of Fecility	eral Dir			
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> 1	N O D	1 Yes 2 No	Hospital: 1 Inpatie		patient 3[DOA	ther: 4 🗆 Nursin	g Home 5 Res	Idence 6 🗆 Ot	her (Specia	(y)
	ding Pn h. After th funeral	27. Mennel of Deeth	28a. Date of Inju (Month, Da		jury	28c. Inju		28d. Describe	how Injury occu	rred	
Division	tal or Attending P as after death. al Director: After t led in by the funers Certification:	2 Accident investigati 3 Suicide 6 Could not	he		M		Yes 2□No	20f Location	(Street and Num	har or Pur	al Routa Number,
5	or Attendate death Director:	4 Homicide determine	28e. Plece of Inj building, et	ury - At home, far c. <i>(Specify)</i>	m, street, ta	ictory, onice			own, Stata)	ber or nur	ar Hodia Walliber,
	ours filled	29a. Certifier 1 Cartifying F	hysician: To the best	of my knowledge.	death occu	rred et the t	ime, date and old	ece, end due to the	ceuse(s) end m	anner es s	steted.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the Medical Certifical	(Check only 2 Medical Exa	miner: On the besis of and menner st	exeminetion end	or Investige	etion, In my	oplnion, deeth o	ccurred et the time	, date end plece	, end due t	o the ceuse(s)
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		> INCI	50)			D	33681	700	4/	26/	2000
		30. Neme and address of person who	completed cause of d	eeth (Item 23e) (EVZS BU	Type, Print)	MD	217	84 13	80 Pro-	gress	Way
	State Registrar	31. Dete filed (Month, Day, Year) APR 28	32. Registr	er's Signeture	4	Spar	V. 1				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WILLIAM TUBMAN 05 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Howard County General Hospital Columbia 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Sept. 17, 1918 Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours XXM 2DF Yrs. 215-07-5661 81 Director Maryland Usual Rasidence of Decedent filed within 72 hours efter deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or frems 23s or 28s-f ahor the Medical Examinar must be notified at 1 ☐ Yes 21 No Director Maryland Howard Ellicott City 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4013 Crescent Rd. 21042 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? ►XXYas 2 □ No If Yas, Give Year or Dates: ₩₩II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yas 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced white Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 2 Superintendant Sand & Gravel permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: if item 27 is marked other any Injury or other traumatic event 17. Fethar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Francis Tubman Estelle M. Schotta 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eurith M. Tubman / spouse Ellicott City, MD. 21042 4013 Crescent Rd. 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other pleca) Ma Pate 8 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Druid Ridge Cemetery 2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses m01044 22. Name and Address of Facility s Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximata Intervel Batween Onset end Deeth **Physician** Immediata Cause (Final diseese or condition rasulting in deeth) erebrovascular accident /Medical 12 hours Examiner Physician/Medical Examiner 3 months Cance 19 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and nding physicien and use as the burial-tren Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseess or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) P.O. Box 68760. Due to (or es e consequence of) Part II. Other significant conditions contributing to daeth but not resulting in the undarlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Records, Be Completed by director, page 2 should be 24b. Were eutopsy findings available prior to completion of cause of daeth? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case raferred to medical 26. Placa of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Nanpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) P P 4 Homicide To the Hospital or within 24 hours at To the Funeral Dis completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end due to the cause(s) and menner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and menner stated. 29a. Cartifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD. ABE 30. Neme and eddrass of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar 794

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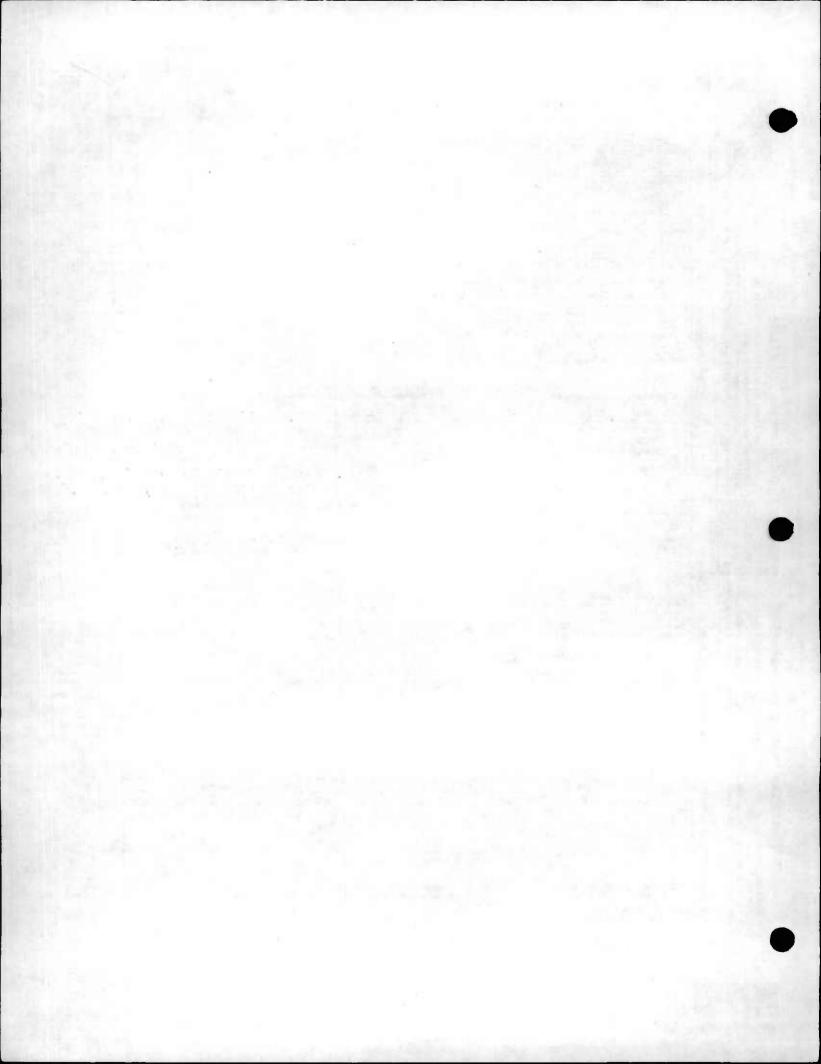
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32. Registrer's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28, 20W 2255 THOMAS W. TRUITT Alric 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number, 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax Months Days Hours 10XM 2□ F Yrs. 216-54-9489 June 16,1947 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Wicomico Salisbury 1 Yes 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33084 Johnson Rd. 21804 US 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Maritel Status Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Production worker Industry for Blind 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah W. Truitt Bessie Truitt 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 33088 Johnson Rd., Salisbury, Md. 21804 Bessie T. Truitt 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Perdue Cemetery May 2,2000 Powellville, Md. 21. Signeture Funeral Seguice Scenses 22. Name and Address of Fecility The Burbage Funeral Home Jenduson Jarrey M. 108 William St., Berlin, Md. 21811 23a 1 st. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, pock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in death) RESPIRATORY Due to (or es e consequence of): 50P5.5 PAYS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2. No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haalth and Mental Hydiene. Important: If itsm 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other treumetic event, the Wedles Exam har must be notified abonce.

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Baltimore, Maryland

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The law requires that the death certificate be executed P.O. Box 68760 Records. been signe should be Division of Vital or Attending Physician: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

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29a. Certifier (Check only one)

State Registrar **DHMH 16 Rev 6/95**

27. Manper of Deeth 1 Neturel 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

29b. Signeture end title of certifier

28a. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

129168

1 Yes 2 No

28c. tnjury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

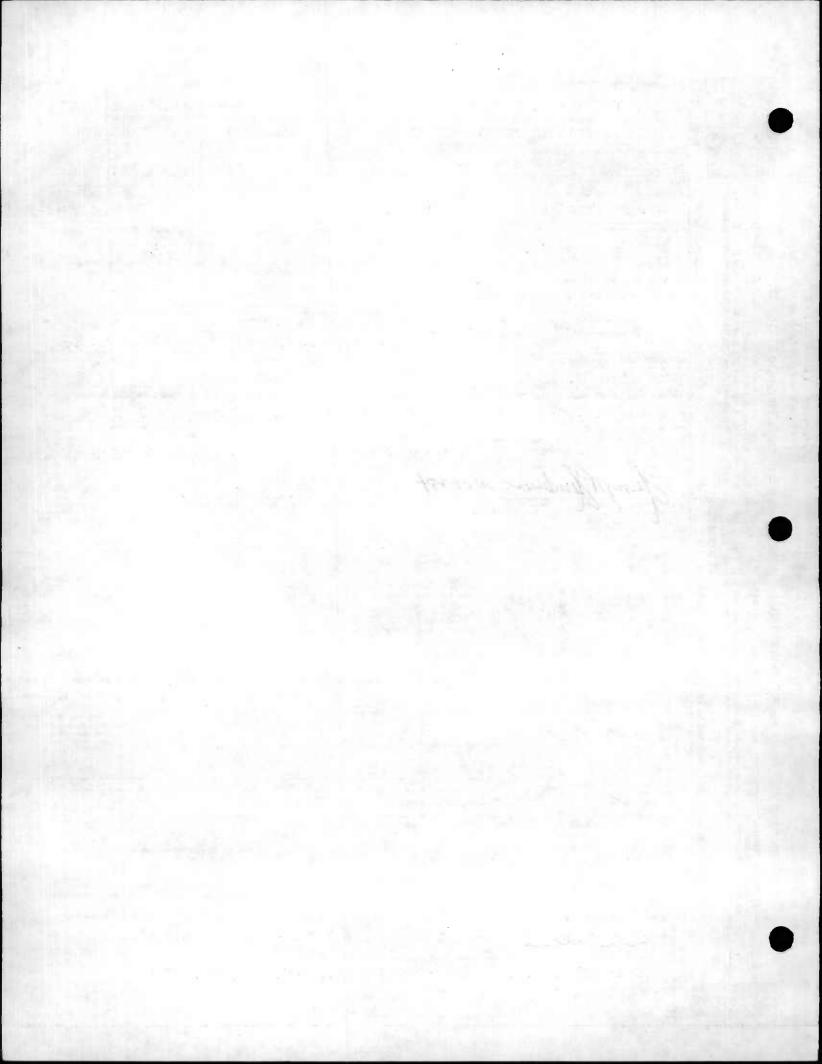
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Allen, M.D.

rale

560 Riverside Dr., Salisbury, Md. 21801 32. Registrer's Signeture

M.D.



1 Tyes 2 □ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

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7 is marked other than "natural", or items 23s or 28s-(show traumstic event, the Medical Examiner must be notified at

permit. Pegas 1 and 2 should be filed within 72 hours efter death a Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural", or items 28e any injury or other traumatic event, the Men

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Saltimore, Maryland 21215-0020

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Division of Vital Records. or Attending Phater description of the Attended In Director: After the vithin 2.

29a. Cartifian 🕰 Certifying Physician: To the best of my knowledga, death occurred at tha tima, deta and plece, and dua to the ceusa(s) and manner es steted. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of cartified causa of daath (Itam 23e) (Type, Print)

Norminia Avenue 30. Name and addrass of parson who completed the Complete Westminster, Md. 21157 31. Deta filad (Month, Day, Year) 32. Ragiştrar's Signatura Registrar

28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Spacify)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Swith Wilma Hansen White 9, May 2000 9:15 am 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Villa Catonsville Baltimore 8. Date of Birth (Month, Dey, Year) May 30, 1911 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) Days Hours 1 M 2 F Months California 88 556-20-0895 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4030 Larkspring Row 21042 United States 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: white 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Real Estate 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William E. Hansen Clara Armstrong 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Christine F. Horn / daughter 4030 Larkspring Row Ellicott City, MD. 21042 20b. Place of Disposition (Name of cemetery, cremetory or other place, 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State May 10 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD. 2000 re of Funeral Service Licenses 22 Name and Address of Facility Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 MOTOGL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdlac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death THROMBOSIS Immediate Cause (Final disease or condition resulting in death) EREBRAC Due to (or as a consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filled within 72 hours aftar death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "neturel", or items 23e or 28a-f show any lolury or other traumatic event, the Medical Exament must be rottled as 2008.

Baltimore, Maryland 21215-0020

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The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

by Physician/Medical Examiner Completed Be Medical Certification: To To the Hospital within 24 hours of To the Funeral Complately filled

if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence or):			
Cause (Diseese or Injury that initiated events resulting in death) Last	C. Due to (or as a consequence of):			
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Part II. Other significant conditions #12+#E1M1	1	sulting In the underlying cau	se given In Part I.	23b. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Junknow
	7			24a. Was an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 🔀 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?				eeth (Check only one)	
1 ☐ Yes 3 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ DOA	Other: 41 Nursing	Home 5 ☐ Residence 6 ☐ Ot	her (Specify)
27. Manner of Death ↑ Statural 2 Accident 2 Accident		28b. Time of Injury M	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how Injury occu	irred
3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, o	office	28f. Location (Street and Num City or Town, State)	ber or Rurel Route Number,
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurred at ation end/or investigation, in	the time, date and place my opinion, death occ	ee, and due to the cause(s) and meturred at the time, date end place	nenner es steted. , and due to the cause(s)
29b. Signature and title of certifier	La 1000	29c. L	icense number) & \$195	29d. Date sign	ed (Month, Dey, Yeer)

State Registrar

ASNEEM 31. Date filed (Month, Day, Year)

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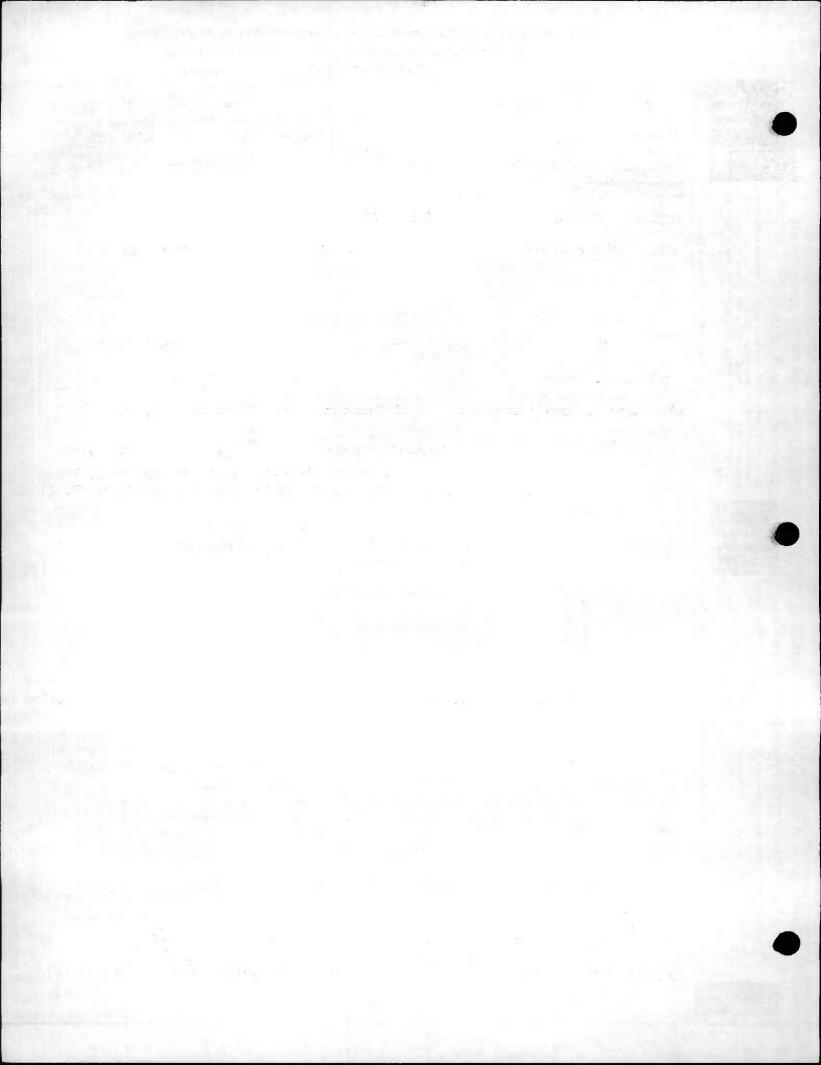
RHANI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7220 PARK HEIGHTS AVE BALTOM)
sture

B. Sparls

DHMH 16 Bay 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death RAIDH C. WILLAMS mA 600 AM 05,2000 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia If Under 24 Hrs. Hours Min. Howard Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 M 2 F Days Yrs. Bloomfield, NJ 213.28.9410 70 09.05.1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Howard Elkridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5808 Harman Ave 21075 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1/ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Car Sales Service Writer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph C. Williams, Sr Laura V. (Hare) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5808 Harman Ave. Elkridge, MD 21075 Marie M. Williams- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 D Burial 2 Cremetion 3 Removal from State 0508≱000 Elkridge, MD Meadow Ridge Mem. Park 2000 Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman Fun'l Home @ Mead Ridge Mem.Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licensee .Marshall M01050 7250 Washington Blvd. Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart tailure. List only one cause on each line. Approximate tntervat Between Onset and Death tmmediate Ceuse (Final disease or condition resulting in death) RENAL CHRONIC inketes Mellita

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permit. Peges 1 and 2 should be filed within 72 hours after death w Department of Health and Mentel Hygiene. Important: If Item 271s marked other than "natural", or Items 23a and Injury or other traumatic event, the Medical Exempter 2006.

Baltimore, Maryland 21215-0020

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Pert II. Other eignificant conditions of	ontributing to death but not re	sulting in the underly	ing cau	se given in Part I.	23b. Did tobacco use co	ntribute to the cause of death? 3 Probably 4 Unknown
					24a. Was an autopsy performed?	24b. Were autopsy findings evailable prior to completion of cause of death? 1 Yes 2 No
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examiner?	Hospitat:	ER/Outpetient 30	DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investigation		28b. Time ot Injury	28c	tnjury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be determined	28e. Pleca of Injury - At I building, etc. (Spec	home, farm, street, fa	ctory, c	office	28f. Location (Street and Number City or Town, State)	ber or Rural Route Number,

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I A hours after dea...-real Director: After

29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title/of partities 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

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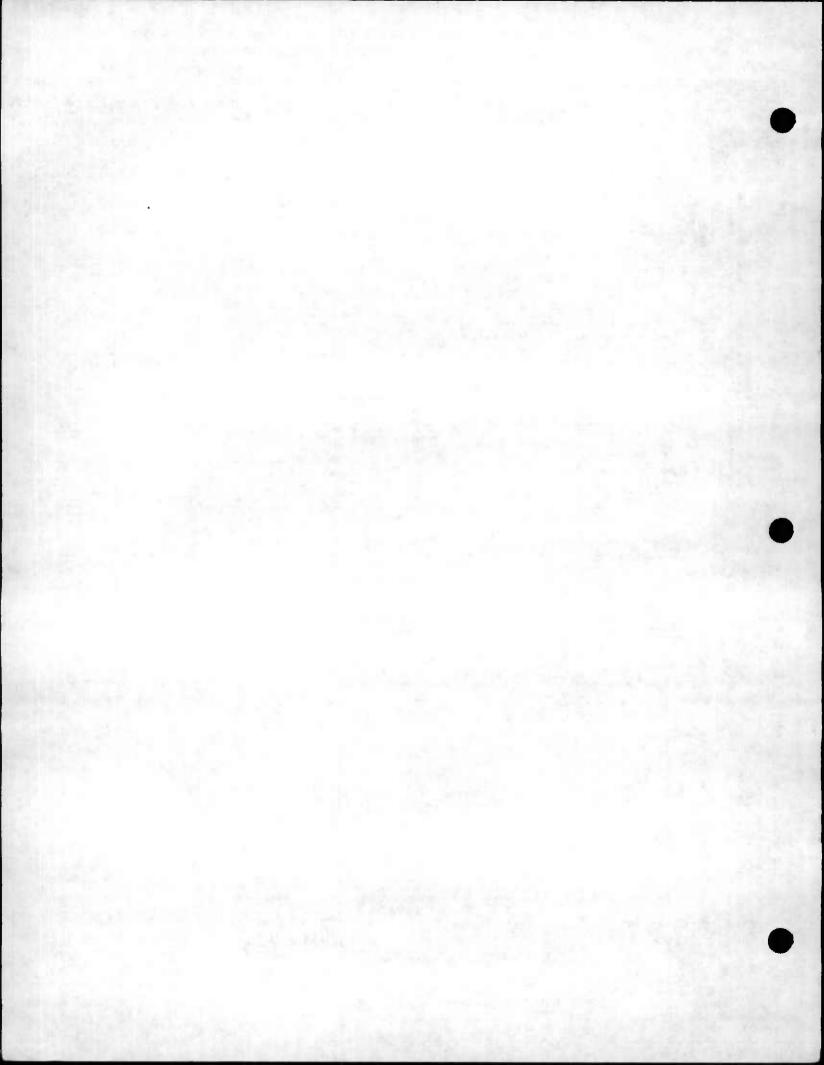
WILLIAM SAWAY 31. Dete filed (Month, Day, Year) MAY 1 1 2000

32. Registrer's Signeture

MD

NORTH. DV. Columbia

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> 2 Accident 3 Suicide

4 Homicide

29a. Certifier (Check only one)

Funeral Director

Be Completed by

Physician

/Medical

Examiner

Funeral

Director

pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f show any fujury or other traumatic avent, the Meulcal Examinar must be notified at once.

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Rebeco	ca WII	liams							April	1 3 0		Yeer	9:40 am
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2 4 3 - 6 2 - Usuel Residence		1□M 2\$0F	58	Yrs.		Deys	Hours	Mir.	8/27/				th Carolin
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Md	Wic	comico	Sa	alisbu	ury								1 ☐XYes 2 ☐ No
10e. Street end No.	lu <i>m</i> ber				10f. Zip (Code 2180)4			10g. Clt		What Cou	
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25. Wes case refe examiner?	arred to medical					100		of Deet	th (Check only	one)			
1 ☐ Yes 2 🔀			•	ER/Outpetien			4 KM 14 N		ome 5 Resi				ify)
27. Menner of Dee 1 ⊠Neturel 2 □ Accident	5 Pendin	ing (Monitorial (28e. Dete	of Injury oth, Dey Year)	28b. Time of Injury	of 28	8c. injun Worl	ryat rk?]Yes 2∐l		28d. Describe	how injur	ry occur	rred	

within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physicien end completely filled in by the funerel director, page 2 should be detached for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical Examiner

> Physician/Medical Examiner þ Medical Certification: To Be Completed

State Registrar 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner stated.

29c. License number

29d. Dete signed (Month, Day, Year)

2000

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

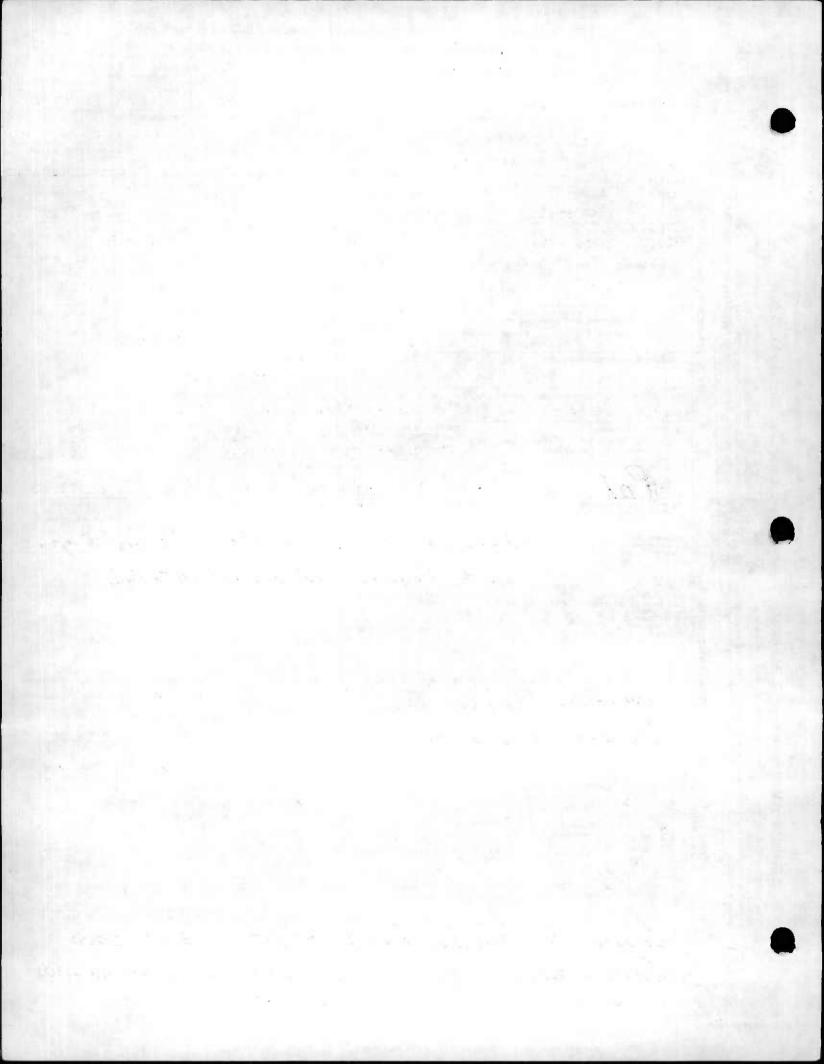
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELLOSO, M.D.; 5 5302 GREGORIO M. 31. Dete fited (Month, Dey, Year)

MAY 0 1

6 Could not be determined

Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Yee CHARLES **Physician** J. WHITE 1413 4 2000 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth `Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Yeer | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Dete of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Deys 15€M 2□ F 195-14-5956 75 Yrs Director 6 - 10 - 24Usuel Residence of Decedent death with the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MD. WORCESTER OCEAN PINES 1≱ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A.

14. Reca - American Indien,
Bieck, White, etc. 10 Bridgewater 21811 RD. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give WW I I Year or Dates: WW I I 1 Never Merried 25 Married 1 Yes 2 Mo Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER INSURANCE 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be 5 ERMA GUTHRIE VERA CHARLES LEONARD WHITE 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 10 Bridgewater Rd. Ocean Pines, Md. EVELYN O. WHITE/ SPOUSE altimore, 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State BERLIN, MD. GARDENS OF THE PINES 5-1 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. 21811 23a 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final VANY YEARS disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in death) Lest Due to (or es e consequenca of): Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 Tyes 2 No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1€ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 28c. tnjury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 24 hours Funeral 29a. Certifier (Check only one) 1 Certifying Phyetcian: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and plece, end due to the ceuse(s) end menner steted. Medical To the within 2 To the 29d. Dete signed (Month, Dey, Year) 29c. I Icense number 29b. Signature end title of certifier 0 06241 04-28-00 30. Name end eggress of parson who completed cause of deeth (Item 23e) (Typa, Print) 203 SNOW ST. SNOW HILL, MD. 21863 POROTHY 40LZWORTH 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

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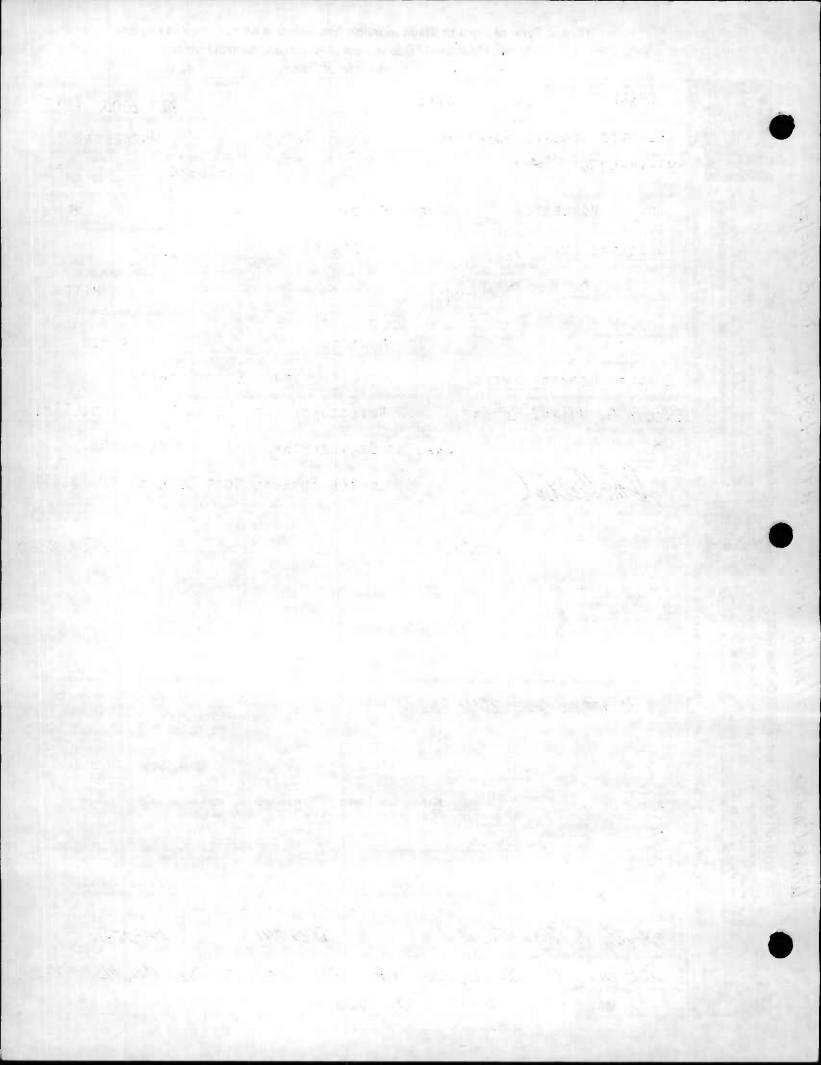
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Piease Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. amend item 23a,b per phys. G783 5/16/00 yg Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month GROVER 12.30 pm WEATHER BEE 00 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOMERSET MCCREADY CRISFIELD HOSPITAL 7. Aga (In yrs. last birthday) If Un r 1 Y r if Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Birthplaca (Stata or Foreign Country) 1 MM 2□ F Days M9 Yrs. Months 224-14-8871 Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD **Funeral Director** Om elseT MESTOVER 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 30049 21871 U.S.A Neck 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva 1 Yas 2 No Specify: Completed by Black 3 ☐ Widowad 4 ☐ Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) HOG FARM SEIF- EmployED 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) Be WEATHER BEE Kedmond 2 MAZU C EDMOND 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) PEGGYNECK RD PRINCESS Daughter DEILA LAKE 20c. Location - City or Town, Stata MD 21863 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition Data cematary, crematory or other place) 1 ଔ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata John Wesley Cemetery

Resulting Address of Facility 4-15-20 Princess Anne MD 4 ☐ Donation 5 ☐ Othar (Specify) of Funeral Sarvice Licensaa Anthony E. WARD Funeral to 30639 Hampden AVE Prince to antar the mode of dying, such as cardiac or raspiratory arrast, Funeral Home Princess Anne, MD 21853 23a. Part1. Enter the disease or complications that caused the feath. Do not anter the mode of dying, shock, or heart failure. Lift only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) SEPSIS **Examiner** Dua to (or as a consequence of): Physician/Medical Examiner UMONIA ASPIRATION PNEUMONIA Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequanca of): ASPIRATION Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown TNFECTED PENILE ULCER þ Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DIABETEC FAILURE CONGECTIVE HEART 1 Yas 2 No 1 ☐ Yas 2 No 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Chack only ona) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannag of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 3 Suicida

I or Attending Physician: The law requires that the death certificate be assouted and redeath.

Director: After this certificate has been signed by the attending physician and of in by the Inuneral director, page 2 should be deteched for use as the burnerial result. Division of Vital Records, P.O. Box 68760, filled in by

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Importants if Rem 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinal must be nothed at

Maryland 21215-0020

Baltimore,

6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Cartifiar 2 Madical Examinar: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signatura and title of certifier -

D 6052293 M.D.

29c. Licansa numbar 29d. Data signad (Month, Day, Yaar)

BALAGURUMURTHY, BALAKRISHNAN

HE MAIN STREET CRISFIELD IND -21817

4.11.00

State Registrar

Medical

31. Data filed (Month, Day, Yaar)

32. Ragistrar's Signatura



To the Hospital e within 24 hours a To the Funeral D

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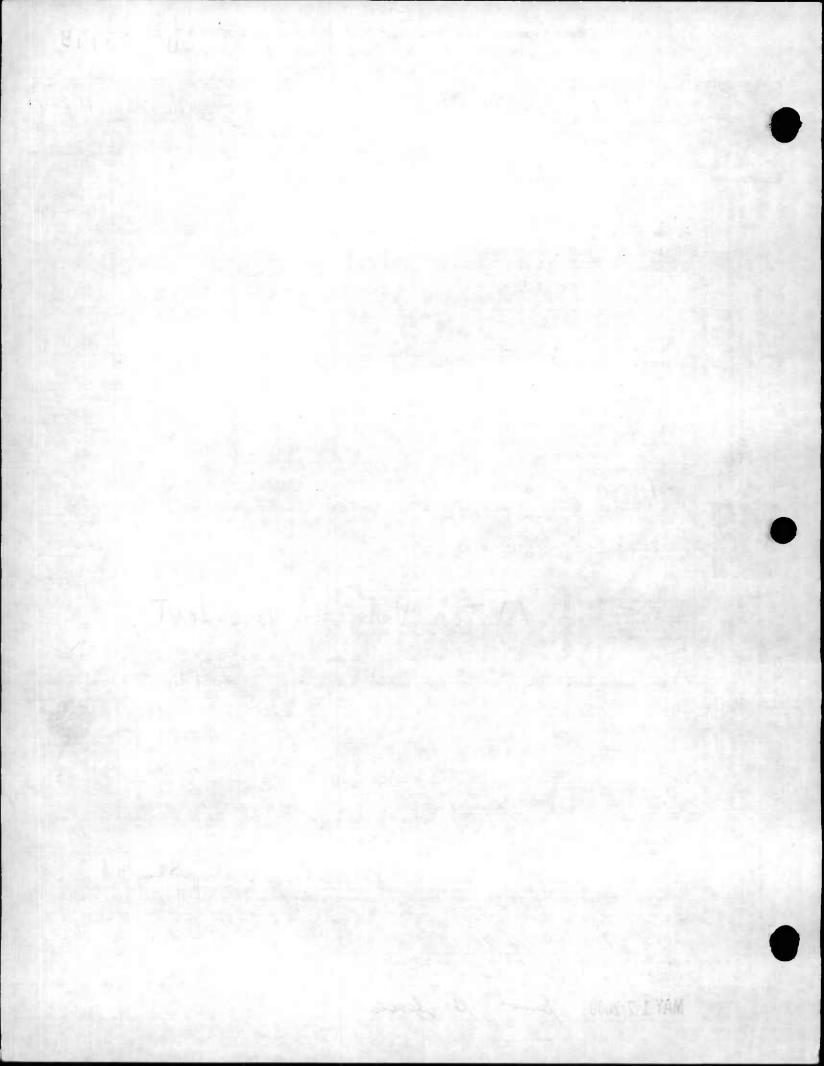
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by Funeral Director	11. Marital Status 1 Nevar Mer 3 Widowed			12. Was Decede Armed Force 1 2 Yas 2 If Yes, Giva Year or Date	ss? □ No		Was Decedent It Yas, specify (1 ☐ Yes 2 [☑]		panic Origin? (, Mexican, Puar Specify:	Specify Yes or Note Rican, etc.)	14. F E Spe	lace - Amaric Black, Whita, a city:	atc.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth CALVIN AYERS Month **Physician** 3:59A 2000 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bon Secours Hospital Balto If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 217-40-3664 56 **Director** Md Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f shov traumatic event, the Medical Examiner must be notified as Director Md N/A 1 ¥ Yes 2 □ No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1513 Presser Court 21217 USA or itema 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 11 Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after c. Department of Health end Mentel Hygiene. I mortant: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Expenses 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Forklift Operator 12th grade Tupper Ware Co 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles R. Ayers Ora M. Flovd 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lilton Ayers- Brother 6806 Brompton Road Balto, Md 21207 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State MXBurial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Memorial Park 5-18-00 Arbutus, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Wabash Avenue Balto, Md 21215 23 Part I. Enter the disease, or corporations that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical immediate Ceuse (Finel disease or condition resulting In death) SEPTIC SHOCK Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): burial-tran end SRONCHO PNEUMONIA attending physician for use es the burial Records, P.O. Box 68760. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy Dertension ARTERY DISEASE ORONARY 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director; to Be 25. Was cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 1 inpatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) and manner steted. Medical (Check only one) 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) D08291 Hospital, 2000 W. BALTIMONE St., BALTIMONE, Md, 21223 Bon SECOURS 32. Registrar's Signeture State

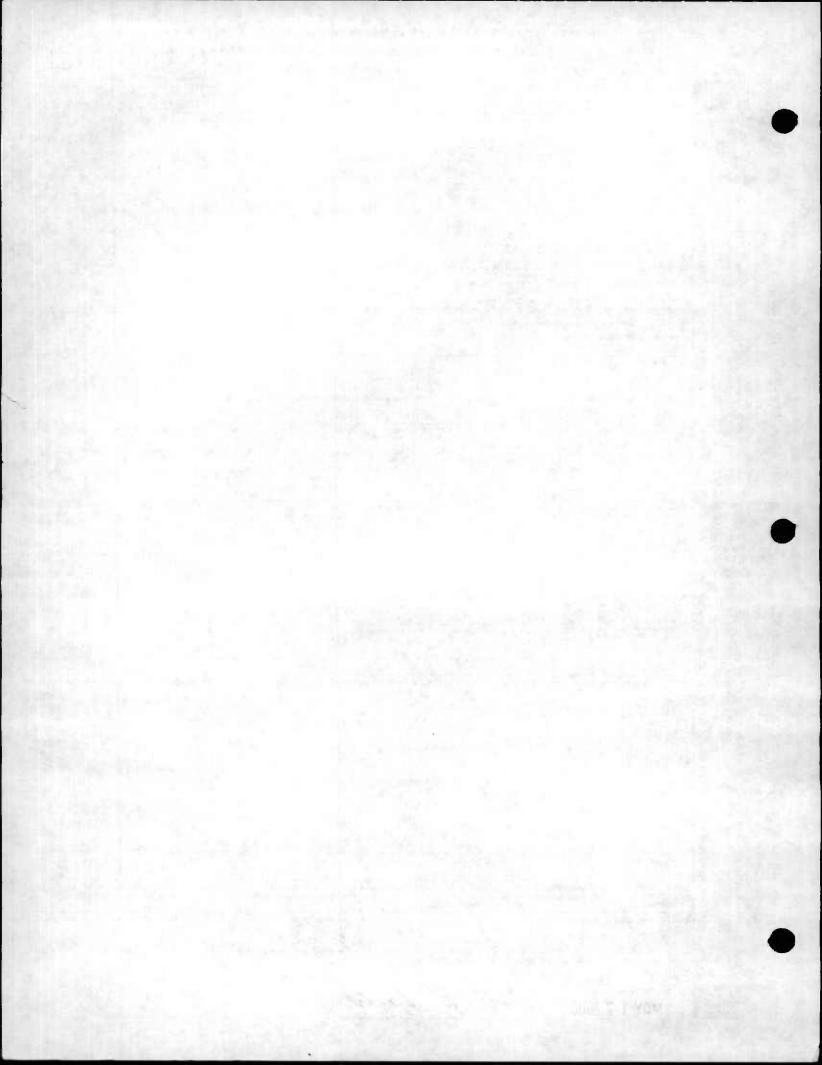
Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 1575

		Reg. No.	
	2. Dete of De Month	eth	3. Time of Death
DLER	MAY 15		5:50 A.M.
4b. City, Town, or Lo	ocation of Death	4c. County of	Death
BROOKLAND			BALTIMORE
ear If Under 24 Hrs. bys Hours Min.	8. Date of Bird (Month, De SEP 22	th y, Year) 2, 1916	Birthplace (State or Foreig Country) MD
			10d. Inside City Limit
A THE COLOR OF			1 ☐ Yes 2 🖎 N
NKSBURG		10g. Citizen of Whe	
.048		U.S.A.	it Country?
ot Hispanic Origin? (Sp Cuben, Mexican, Puerto No Specify:	ecity Yes or No Rican, etc.)		American Indien, White, etc. WHITE
ccupation one during most of work tired)	ting	16b. Kind of Busin	ess/Industry
OKKEEPER		ADLER DIS	PLAY CO.
18. Mother's Nem	e (First, Middle,	, Meiden Sumeme)	
MARY		М.	MASEROW
reet and Number or Rui			
Y LORI EAST	- FINK	SBURG, MI	21048
piece)	Dete	20c. Location - Cit	y or Town, Stete
	5/16/00	THE TOTAL	INT ME
N CEMETERY Idress of Fecility		*	
			BROS., INC.
			E, MD 21208
dying, such es cardiac	or respiretory e	rrest,	Approximete Interval Between Onset end Deeth
			3 days
given in Pert t.	23b. Did	tobacco use contri	bute to the cause of deat
	1 🗆	Yes 2 No 3	Probably 40 Onkno
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		an eutopsy 2 ormed?	24b. Were autopsy tinding eveileble prior to completion of cause
			ot death?
	10	Yes 20No	1 ☐ Yes 2 ☐ No
26. Place of Deel	th (Check only	one)	
Other: 4 Nursing He	ome 5 Resi	denca 6 Other	(Specify)
Injury et Work?		how injury occurred	
lica	28f. Location (City or To		or Rurel Route Number,
e time, dete end pteca, ny opinion, deeth occur			
cense number		29d. Date signed (/	Month, Dey, Year)
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01.00 110	na.	0	
riresulle,	M()		
	ry opinion, deeth occur cense number 1426 Pike wille	cense number	1426 May 15

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State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day 8 50 Month Yee **Physician** JESSIE 2000 05 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Deeth Examiner NIA PARKWAY BALTIMORE TIOGA If Under 1 Year | If Under 24 Hrs. Dete of Birth (Month, Day, 12-28-5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 10 M 20 F Yrs. 10 Director 143-32-4188 Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits with the Maryla 1 Yes 2 No mo NIA BALTIMORE Directo 288-f 10e Street and Number 10f Zip Code 10g. Citizen of Whet Country? Name 23a or 3114 TIOGA PARKWAY 21215 ARU Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Eyer in U,S. Armed Forces? 11. Meritel Status hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married ò altimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1,4or 5+) 12 TH GRADE DOMESTIC HOME NIA 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ant: if them 27 is marked o ZEMORIA SAVAGE EDWARD BAILEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) CIR., BALTO. MD. 21228 HOPE UPPER MILL DAUGHTER COLEMAN 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 5.20-00 ARBUTUS CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) BALTO. MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE, BALTO. MD. 21229 23a. Pert1. Ente (the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death Physician /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760. attending physician the Due to (or as a consequence of) 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 25 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy pertormed? Completed page 2 1 ☐ Yes 25 No of Vital Physician: 25. Was case referred to medicel examiner? 26. Piece of Deeth (Check only one) edical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Deeth Natural 28b. Time of injury 28c. Injury et Work? Division or Attending 5 Pending investigation ours after death. Jeral Director: Af filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospita Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signeture end fitle of certifier 29c. License number 30. Name and address of person who completed ceuse of death (Item 23a) (Typa, Print) BLADMO st Baltimore Greens VAN South 32. Registrar's Signeture 31. Dete filed (Month, Day, Year) State Registrar

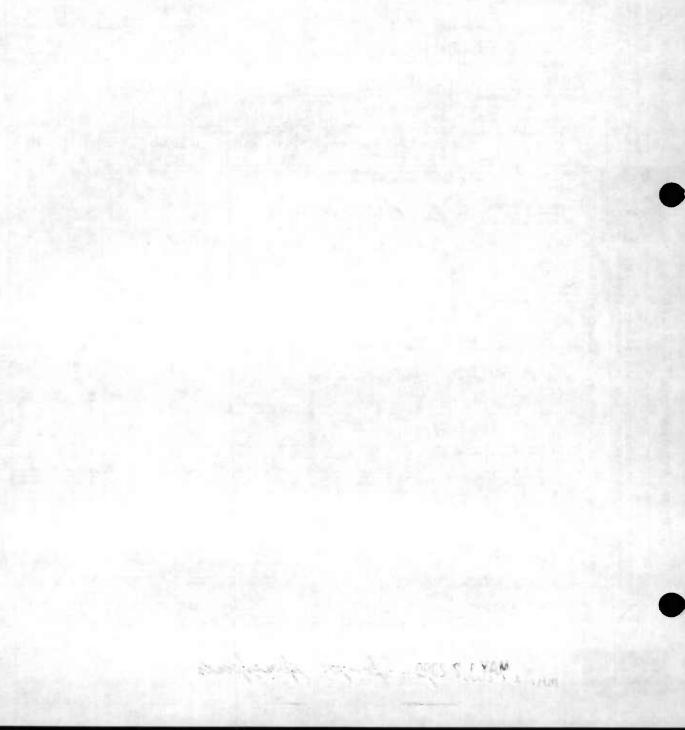
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State of Maryland / Department of Health and Mental Hygiene 00 15753

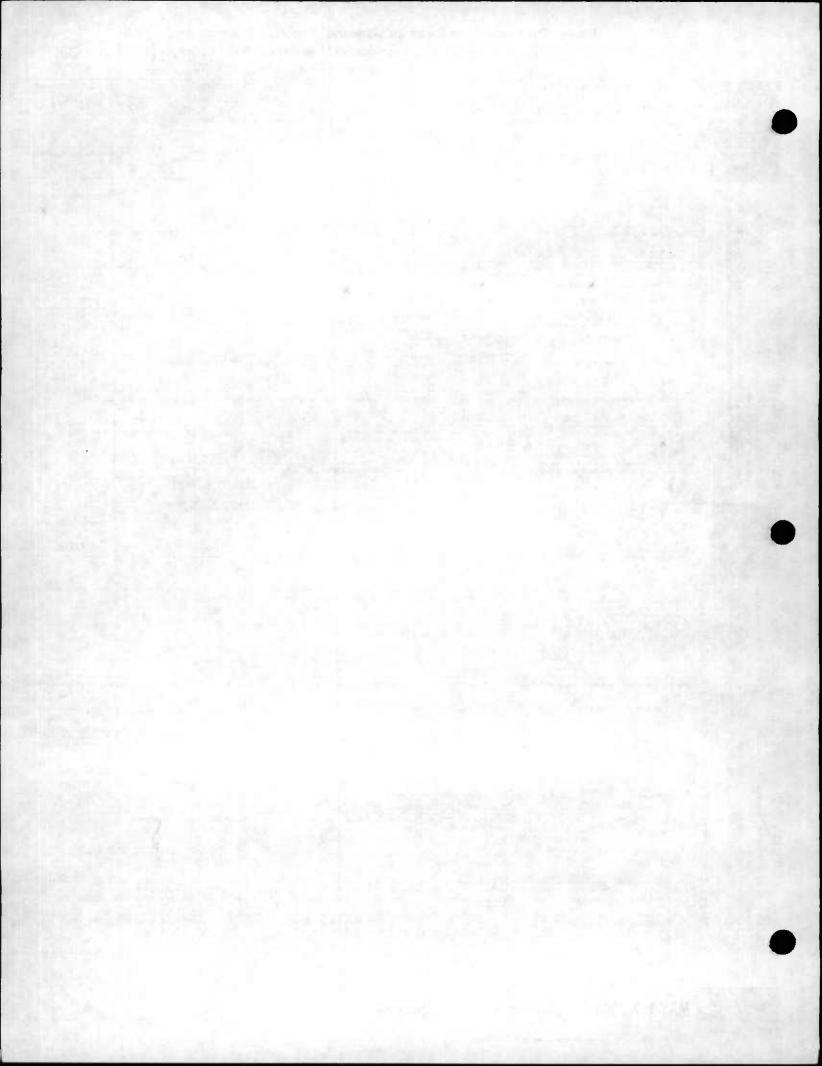
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MD NA Oe. Street and Number DO BOOKER RO 1. Meritet Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementery/Secondery (0-12) L TH GRADE	AD APT. A 12. Was Decedent Ever Armed Forces? 1 Yes, Give Yeer or Detes:	ALTI MO	101. Zip C	228		10g. Citizen of W	1 🗹 Yes		
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(Specify only highest grade Elementery/Secondery (0-12)	ucetion			No Specify:	o Hican, atc.)	k, White, etc. BLACK			
Elementery/Secondery (0-12)		16a. De	cedent's Usuel	Occupation	rkina	16b. Kind of Bus			
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						, Maiden Surneme	a)		
HOWARD BROWN				AUGUSTI	1 GASS	AWAY			
19a. Informent's Name/Reletionship (T		19b. M	eiting Address (Street and Number or R		er, City or Town, S	Stete, Zip Code)		
ALAN BROWN S	SON	1287			ST., BA				
/	and the second s	b. Plece of Discemetery, of	sposition (Neme cremetory or oth	of er piece)	Date	20c. Location - 0	City or Town, Stete		
) British Stelle	ARRISO	N FORF	31	5.18.00	8.00 OWINGS MILLS, MD			
21. Signature of Funeral Service Licens				Address of Facility					
Mayor C	M		1 00						
23a. Pert1. Enter the disease, or comp	licetions that caused that	death. Do not					Approximete		
shock, or heert feiture. List only o	one ceuse on each line.						Intervet Betwoonset end D		
Immediate Cause (Final	0.						1		
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Cause (Diseese or injury	· Deme	enti	a			10 yea			
resulting in death) Lest	Due	o (or es e cons	sequence of):						
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					10	Yes 2 No	1 Yes 2		
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	28a. Deta of Injury (Month, Dey Yea				28d. Describe	how injury occurre	be		
2 ☐ Accident investigation			M	1 Yes 2 No					
3 Suicide 6 Could not be determined	289. Piece of injury -	At home, ferm, pecify)	street, fectory,	office	28f. Location City or To	Street end Number wn, Stete)	er or Rurel Route Numi		
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one)	end menner steted.	rough and/o							
29b. Signeture and title of certifier	0 10						(Month, Dey, Year)		
Krotin MCE	ark un)	0	005396	0	05/	17/00		
30. Neme and address of person who c	ompleted ceuse of deeth	(Item 23a) (Ty	pe, Print) K	ristin mo	Jark N	no wi	LKEWS HEAC		
4660 W. 1Ke	ns Avenue	Svite	100 B	111 000	mn	71770			
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State of Maryland / Department of Health and Mental Hygiene 1 5754

			Certific	ate of Death	R	eg. No.	10101			
Physician /Medical	1. Decedent's Name (First, Middle, Las ANNA LEE P	RAUTIGAL	V		2. Date of Dea Month	Day	Year 18:46			
Examiner	4a Facility Name (If not institution, give	street and number)	PITAL	4b. City, Town, or PALTIW	Location of Death	4c. County of	of Death			
Funeral Director	211-20 0001		. last birthday) If U	nder 1 Year If Under 24 Hr. ths Days Hours Min	. (Month, Day	Year) 194	9. Birthplece (Stete or Foreign Country) 40 Maryland			
fland	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limits			
her death with the Maryla Rems 23e or 23e4 sho frer must be notified at Funeral Director	MD Anne An	rundel Pas	sadena				1 ☐ Yes 2 No			
or 28a-f s be notified Director	10e. Street and Number	The Water	10f.	Zip Code	1	0g. Citizen of W	het Country?			
ath w	347 Sturtons I			1122		J.S.A.	A martin and an			
Mr. or	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		ecedent of Hispanic Origin? (specify Cuban, Mexicen, Puess 2 No Specify:	specify Yes or No- rto Ricen, etc.)	Specify:	American Indien, White, etc.			
od within 72 ho ygiene. er then 'netur t, the Medical.	15. Decedent's Edi		16a. Decedent's l	Jsuel Occupation work done during most of wo Tuse retired)	orkina	16b. Kind of Bus	siness/Industry			
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should and Mo marks ametic	19a. Informent's Neme/Relationship (T	vpe. Print)	19b, Mailing Add	Naomi ress (Street and Number or F		r, City or Town, S	Stete, Zip Code)			
nd 2 27 is 27 is	Raymond Brautic		d) 347	Sturtons La	ne Pasad	dena. N	4D. 21122			
f Hear Herm office	20a. Method of Disposition	206.1	Plece of Disposition cemetery, crematory	(Neme of			City or Town, State			
Page nati it ny or	1 Buriel 2 Cremation 3 1 4 Donation 5 Other (Specify	Hemoval from State	The second secon	Mem. Garden	s 5-18-	00 Svk	kesville. MI			
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/Medical Examiner	Immediete Cause (Final disease or condition resulting in deeth)	a. Rheumato	or es a consequence	ng Disease	2		MONTHS			
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attendin for use		d	****							
0 0 0	Pert II. Other eignificant conditions co	ntributing to death but not res	sulting In the underlyi	ng cause given in Part I.	23b. Dld to	obacco uae con	tribute to the cause of death			
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aw requires been 2 shou	Breast Cancer	- 20 years pu	nor		24a. Was e perfor	n autopsy med?	24b. Were autopsy findings available prior to completion of ceuse of death?			
The pege			No.		HØ Y	es 2 No	1□ Yes 2₽No			
clan: ector Be	25. Was cese referred to medicel examiner?	Hospital:		Othor	eath (Check only or	and the second				
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tal or Attending Physician: The is as after death. al Director: After this certificate had in by the funeral director, page Certification: To Be Com	1 Neturel 5 Pending investigation 3 Suicide 4 Homicide 1 1 1 1 1 1 1 1 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Speci	Injury	28c. Injury at Work? 1 Yes 2 No		28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Ni				
within 24 hours after the Funeral Director Completely filled in Medical Cert	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	elclan: To the best of my kno	owledge, deeth occur	rred at the time, date end plection, in my opinion, deeth occ	ce, and due to the c	ause(s) and mer	nner es stated.			
Med Med	one)	and manner stated.				T-9 PO	A STATE OF THE PARTY OF THE PAR			
5358	29b. Signature and title of certifier	200		29c. License number P12413		5/13/8	(Month, Day, Year)			
(Va)	30. Name and address of person who of		m 23e) (Type, Print)	e MD						
State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	nature							



State

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Mont MCA) Year) 7

DAVID R. FOWLER M.D.

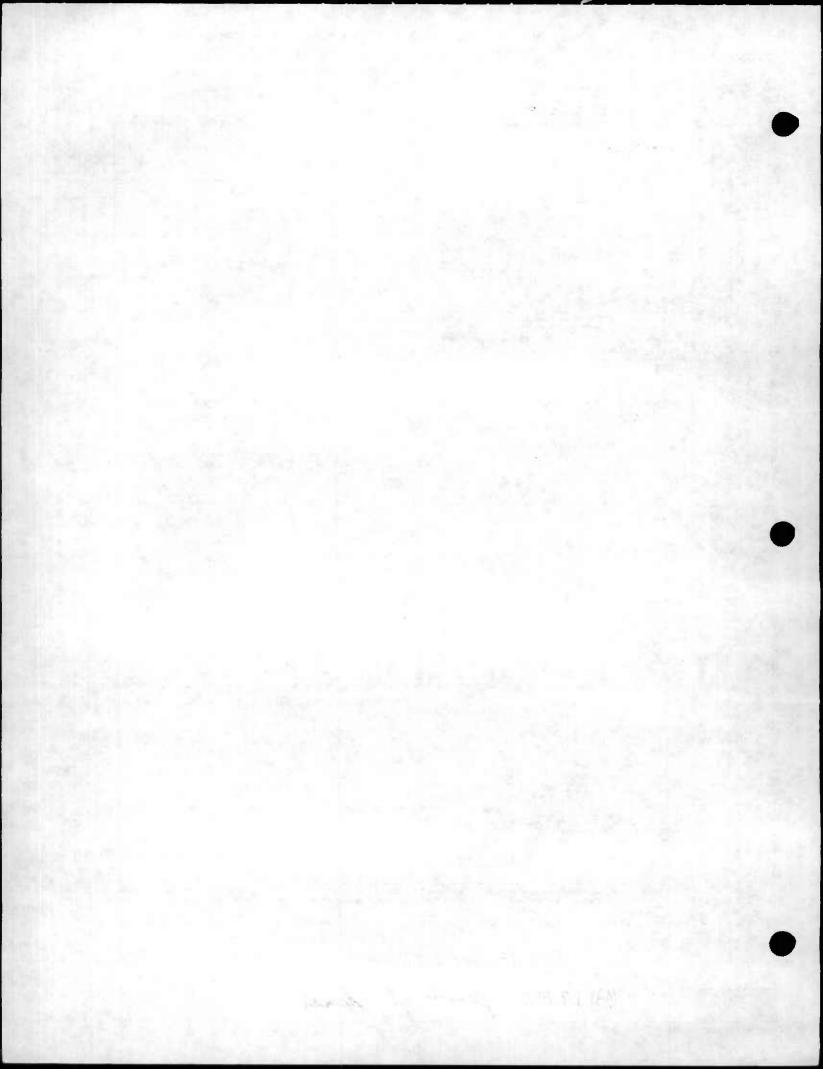
30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

MAY 13,2000



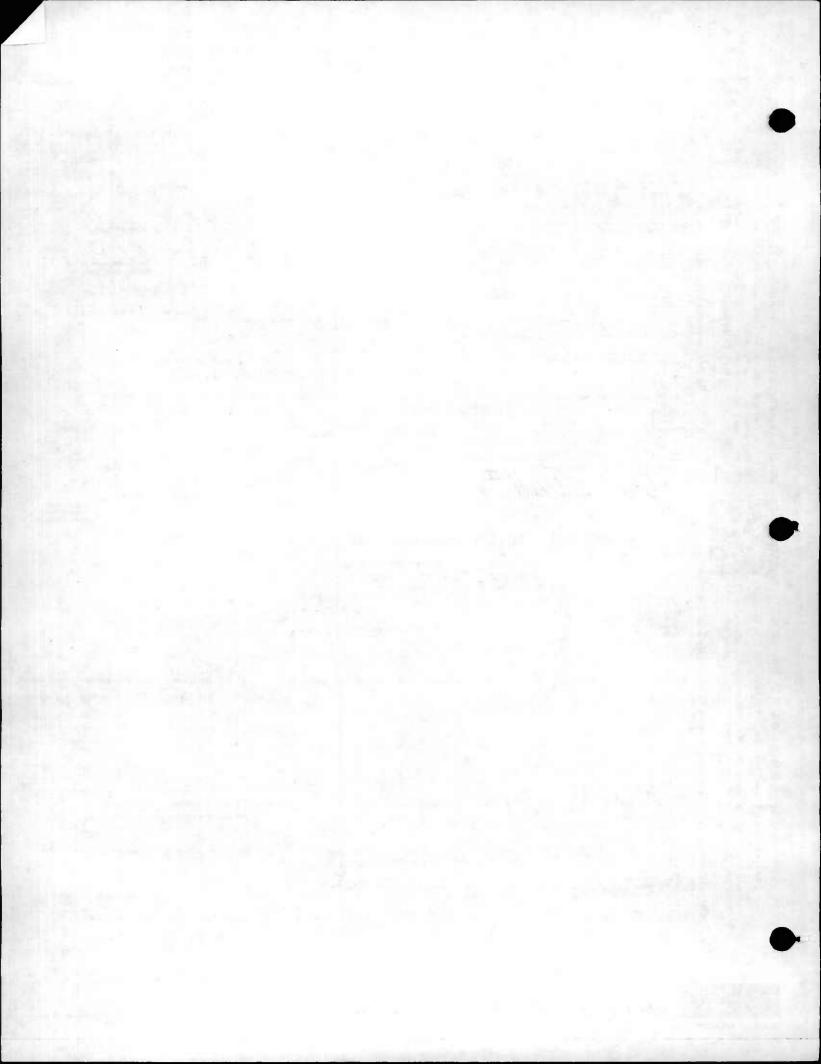
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death

L			47.3		86	riato or	war yrar		tificate of				Reg. No.	15/	56
	Physicia	an	1. Decedent's Nan	ne (First, Middle	e, Last)				1112			2. Dete of De Month	ath Dey	Yeer 3.	Time of Death
	/Medic		AGNES									MA	Y 14,		:30 PM
	Examin	er	4e Facility Neme (+	100			cation of Deet		·	
			5. Sociel Security I		6. Sex			last birthday)	If Under 1 Yeer		r 24 Hrs.	P Date of Bir		Baltim	
	Funeral Director		219-30-9	431		2 X F	89		Months Deys		Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (Stete or Country) Maryland			and
	pue Maria		10a. Stete	10b. County			10c. Cit	ty, Town or Loc	cation					10d. Ir	nside City Limits
	ith with the Meryler 23s or 28s-f show ust be notified at	to	Maryland	Baltin	ore		ı	imoniu	m					1	☐ Yes 2XXNo
	7 28 th	irec	10e. Street and Nu						10f. Zip Code				10g. Citizen of	Whet Country?	
	23ª V	rai	2300 Dul	aney Va	ılley	Rd.			2109	3			United	States	- THE T
	uid be filed within 72 hours efter death with the Meryland Mental hygiene. rrked other than *natural; or frems 23s or 23s-f show rite event, fre Medical Examination must be notified at To Be Completed by Funeral Director		11. Meritel Status		1	Armed Force	ent Ever in U es?	,S. 13. V	Ves Decedent of I Yes, specify Cub	Hispanic O an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	ce - American In ick, White, etc.	dien,	
21215-0020			1 X Never Men 3 ☐ Widowed			1 Yes 2 If Yes, Give Yeer or Dete		1 ☐ Yes 2 No Specify:					Specil	white	
2	72 h	etec	(Spe	15. Deceden	t's Educati	on empleted)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of B	susiness/Industry	/
121	within then then	du	Elementery/Seco		1	College (1-4	or 5+)	homemaker						1	
	Hygle ther mt, p	ပိ	17. Father's Neme	(First, Middle,	Last)		18. Mother's Na					/First. Middle		home	
an	2 should be filed end Mentel Hygi is marked other raumatic event, To Be Cc	o Be	John J.									ne P. K		,	
a Z	2 should end Me mert		19a. tnforment's N	eme/Reletions	hip (Type,	Print)		19b. Meilin	g Address (Street	t end Numl	ber or Rura	al Route Numb	er, City or Town	, Stete, Zip Cod	e)
Σ	and 2 Belth e n 27 ls		John F.	Burgan,	nephe	ew			Lamaze		Ba1	timore,	MD 21	234	
ore	ーエミセ		20e. Method of Dis		2 Dom	aval from St	20b. F	Plece of Dispos cemetery, crem	sition (Neme of netory or other ple	ice)	1	Dete	20c. Location	- City or Town, S	Stete
aitimore, Maryland	Peges ment of fa		4 Donetion			over morn Su	Pa		Cemetery	•	1			nore, Ma	
Ball	Depart Import any In		21. Signature of Fi	meral Service	Licensee	11 1		22.	. Neme end Addre	ess of Feci	6500	York :	Rd.		1 Home, In
		-	238 72111. Enter	the disease, or	complicet	ons that cau	sed the deet	h. Do not ente	er the mode of dyi	ng, such e	Balt s cardiac d	imore,	MD 212	212	proximate
) [hysician /Medical				only one o									Ons	rvel Between set and Death
	Examiner		Immediate Cause (Finel disease or condition resulting in death) SEVERE METABOLIC ACIDOSIS												
		er				DENIOL		or es e consequ		cenc	TC				
	d d ensit	mir	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury cause.												
ó	an an	EX													
68/60,	tificate be executed g physician and es the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of):												
õ	_ 0 0	92													
Š Q	the deeth cer y the attendir oched for use	Physician/			0									1	
j	the de	ysic	Pert II. Other signi	ficant condition	ns contrib	uting to deat	h but not res	ulting in the un	nderlying cause gi	ven in Pert	t.	23b. Did	tobacco use co		cause of death?
ν. Γ	D D D	by Ph										10	Yas 2□ No	3 Probably	4 Unknown
ras,	quire en sig ould b	8										24a. Was	en eutopsy omed?		utopsy findings le prior to
	law re es ber 2 sho	piet										pen	illied ?	comple of death	tion of cause
r	sician: The law certificate hes t lirector, page 2 s	Completed										1 🗆	Yes 2 No	1 🗆 Yes	s 2 No
VII	otor,	Be	25. Wes case reference	red to medica							e of Deeth	(Check only	one)		
0		P	1 ☐ Yes 2 🔀		Hos	1 LX Inp		ER/Outpatient	1 3LI DOM				dence 6 Ott		
	Attending P or deeth. ector: After t by the funers	ation:	27. Manner of Deel 1 ■ Neturel 2 □ Accident	h 5 ☐ Pendin Investi	9	88e. Dete of l (Month,	Injury Dey Year)	28b. Time of Injury	M 1□	ryat rk?]Yes 2□		28d. Describe	how injury occu	rred	
DIVISION	or Attendation of Att	Certification	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be ined	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (City or To	Street and Num wn, State)	ber or Rural Rou	ite Number,
	Hospi 4 hou Funer tely fill	edical	29a. Certifier (Check only one)	1 Certifyin 2 Medicat	g Physicis Examiner:	n: To the be On the basi end menne	s of examine	wledge, deeth tion end/or inv	occurred at the tile estigation, in my o	me, date e opinion, de	nd plece, eeth occurre	end due to the ed et the time,	ceuse(s) end m date end place,	enner es steted end due to the	ceuse(s)
	To the To the comple	Ž	29b. Signeture end	title of certifie	_	. 1			29c. Licens	se number		7-84	29d. Date signe	ed (Month, Day,	Year)
	1	1	- No	robonx	- P n	ilor	a m.	0	D414	10		W.	4 14th	, 200	
-	and		30. Neme an Oddi	of person	who comp	eted cause	of deeth (Iten	n 23e) (Type, F	Print)				1	-	
1	(PS		JOGINDE		MEHT	A MD			ER DRIV	E, T	OWSO	N, MA	RYLAND	21204	
	Stat	A	31. Dete filed (Mon	th, Dey, Year)		- 32. Reg	istrer's Signe	eture							

State Registrar

MAY 1 7 2001

Server G. Joseph



Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

Certificate of Death	Reg. No.				
State of Maryland / Department of Health and Mer	ntal Hygiene	5	7	5	
				_	

				Ce	rtifica	te of	Death			Reg. No.			
	1. Decedent'a Name (First, Middle, I	.ast)							2. Data of De		Year	10000	a of Death
Physician /Medical	Carl Cam	pbell i	Burke			9.5	300		May		2000	12	:20 An
Examiner	4a Facility Nama (# not institution, g Union Memoria							wn, or Lo	cation of Beat		of Death		
Funeral	Social Security Number 6.	Sex	7. Aga (In yrs.	last birthdey) Yrs.	If Unde	r 1 Yeer Daya	If Under Houra	24 Hrs. Min.	8. Dete of Bi	rth ay, Year) 25,19	9. Births	place (Stantry)	ita or Foraign
Director	Usuel Rasidenca of Decedant	AA	07	110.					UCE.	25,19	32 M	aryı	and
ahow the	10a. Stata 10b. County		1	ty, Town or Lo							1	iva. Insia	a City Limits
vith the Ma t or 28a-f a be notified Director	Maryland N/	A		Balti								21	Yes 2□No
th with the 23e or 2	3614 Hickory	Avenue			10f. Zi	p Coda 2	1211			10g. Citizen of What Country? USA			
within 72 hours after death with the Maryland ene. then "natural; or items 23e or 28e-f ahow in Medical Examiner must be notified at impleted by Funeral Director	11. Marital Status 17. Never Merried 2 Married 3 Widowed 4 Divorced	Armed F	edent Ever in U orcas? 2 ☐ No iva ^{Datas} Unkn		Wes Dece If Yas, spo 1 Yas	ecify Cubi	lispanic Orl an, Maxicar Specify:	n, Puerto	ecify Yaa or No Rican, atc.)		ca - Amaric ck, Whita, y: W]		
ed within 72 hours ygiene. wr then "neturel", rl, the Medice E.	15. Decedant's (Spacify only highest of	Education		16a. Dece (Giva	kind of w	ork dona	during mos	it of worki	ing	16b. Kind of B	usiness/Ind	dustry	
d within piene. Tr than	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT	use retired	d)						
Hygin C	1 1 17. Father's Name (First, Middle, La:	st)		St	ore	Kee		ar's Name	/First Middle	Groon, Maiden Suman	cery	Sto	re
2 5 5 5 W	Carl Lee Burk						TO HOUSE			th Hami		ro	
2 should be and Mente is marked aumatic ar	19a. Informant's Name/Relationship			19b. Maili	no Addras	s (Street	and Numb			per, City or Town			
T S S S S S S S S S S S S S S S S S S S	Elizabeth Mer		other							ltimore			211
-755	20a. Mathod of Disposition		20b. I	Place of Disponental Company of the	osition (Na	ma of		Venu	Data	20c. Location	- City or To	own, State	2 1 1
	XXBurlal 2 Cramation 3 4 Donation 5 Other (Spec		Stata						17/00	E7 - 37			, ,
permit. Pege Depertment of Important: If any Injury or ODGE.	21. Signature of Funaral Sarvice Lig		1	OFFA1	2. Nama a	nd Addra	cem.	ty 5./	17700	Woodla	awn,	Mar	yland
Deg ding	1 Jun 1	3 01/	200							uneral			
	23a. Part 1. Enter the disaasa, or co	molications that	caused the deal		3631	Fa.	LIS F	Road cardiac	, Bali	timore,	_Md	212 Approxi	11 mete
Physician	shock, or haar failura. List on	y one cause on	each line.							711721		Interval	Batween and Death
/Medical	Immediata Causa (Final	- 11	1.	Car	~ h ~	1 1	. 1		1	1		21	0.15
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entificate be associted ding physician and se as the burial-transit	Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying		Dau 10 (1	01 40 4 001100	quoriou oi,	•							
ficate be physicie is the bu	causa. Entar Undarlying Causa (Disease or Injury that initiated avants	c	Dua to (c	or as a consac	guance of)	:			-		-		
tifica ng ph as th	rasulting in death) Last										i		
ending ruse a		d											
Q 0 Q	Part II. Other significant conditions	contributing to d	laath but not res	sulting in tha u	indarlying	cause giv	van in Part I	l.	23b. Dld	tobacco uae co	ontributa to	o the cau	sa of death?
that the death of the attent detached for us									10	Yes 2 No	3 Pro	bably	4 Unknown
es the igned be de be de													
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The law									10	Yas 2 No	10	Yas	2 No
certificate rector, pag	25. Was casa ratarred to medical						26. Place	a of Daath	(Check only	one)			
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ding Ph. After thi funeral	27. Manpar of Death 1 ☑ Natural 5 ☐ Panding	28a. Data	of Injury oth, Day Year)	28b. Tima o Injury	of	28c. Inju	ry at		28d. Describe	how injury occu	rred		
	2 Accidant invastigati	on			М		Yas 2	No					
or Attendation of the control of the	3 Suicide 6 Could not datermine	d Zoa. Place	e of Injury - At h	oma, farm, st	reet, facto	ry, offica			28f. Location City or To	(Street and Num own, Stata)	ber or Rura	al Routa I	Vum <i>ber</i> ,
Ce rich													
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi	29a. Certifiar 1 ☐ Certifying F (Check only one) 2 ☐ Medical Exi	miner: On that	a best of my kno casis of examina nnar stated.	owledge, deat ation and/or in	h occurred vestigatio	dat tha tion, in my c	me, date an opinion, dea	nd place, a ath occurr	and due to the ed at the tima	causa(s) and m , date and piaca	annar as s and due to	itated. the cau	se(s)
Med Wed	29b. Signature and title of certifiar	A anomar	mai stated.		29	c. Licans	se number			29d. Date sign	ed (Month,	Day, Yea	ar)
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(X)					F	116	-276	17	0	1,47	1	0 :	
5	30. Nama and address of person wh		sa of death (Itar	m 23a) (Type, on Mem	Print)	H~-	11	218	East.	May University M	ity	tark	way
	31. Dete filed (Month, Day, Year)				iorial	1105	1101	Do	ZITIMO	re, M	V 2	121	0
State	o., Doto mod (Month, Day, Fear)	32.	Registrer's Signa	aturo .									

MAY 27 2000 Some & Some

Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Dev Month **Physician** VIOLA C. CARPENTER MAY 12 2000 5:45 PM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE 1803 BELT STREET If Under 1 Yee Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1□M 20 F 56 Nov.30 1943 Director 216-40-0078 Canada Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show ma 23a or 28a-f short Yes 2 No Director Md. n/a Baltimore 10e Street and Number 10g Citizen of What Country? 10f. Zin Code 1803 Belt Street 21230 USA Funeral |tema 14. Race - American Indien, Bleck, White, etc. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus "natural", or Item roles Examiner filed within 72 hours after 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2X No If Yes, Give aitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Baltimore City Elementery/Secondary (0-12) College (1-4or 5+) Secretary 12 Board of Education 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth any Injury or other traumatic event Baca. 17. Fether's Neme (First, Middle, Last) Be Edna Newman Ronald Calder 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 1803 Belt Street, Baltimore, Md. 21230 John H. Carpenter (Husband) 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete 20e, Method of Disposition cemetery, cremetory or other place) 1 ☐ Burlel 2 XCremetion 3 ☐ Removel from Stete 5/15/00 Baltimore, Md. Green Mount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 239 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

App. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner ensive Arterio schrotic Cardio vascular Oscase Examiner ert physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequenca of) Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Infarction 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be

Box 68760. P.0. Records. of Vital To edical Certification: Division Hospital or Attending after death.

Director: Aft
d in by the fur

25. Wes case referred to medical exeminer? 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4□ Nursing Home 5 Residenca 8 □ Other (Specify) 1 ☐ Yes 2 € No 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide tertifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner stated. 29a. Certifier

To the Hospital within 24 hours a To the Funeral Completely filled State Registrar

and address of person who completed cause of deeth (Item 23a) (Type, Print) orge Vallecillo

29b. Signeture and title of cartifier

MAY 1

(Month, Dey, Year)

7 2000

4000 Annapolis Rd. Baltimore MD 21227 m. D.

32. Registrer's Signature

29c. License number

026203

29d. Date signed (Month, Dey, Year)

5/15

100

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** CHARLOTT E 2:45 P.m. CHANEY 05 13 2000 /Medical 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** BALTIMORE HAPPOR MOSPITAL HUnder 24 Hrs. 8. Dete of Birth (Month, Day Year) Min. March 18, 1918 If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign **Funeral** Deys Months 1 M 2 TX 82 Yrs. 216-24-4668 Director Usuel Residence of Decedent with the Manyland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at XX Yes 2 No Director MD Baltimore 10e Street and Number 10g. Citizen of Whet Country? 10f Zin Code 708 Pontiac Avenue 21225 USA death y Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Yeer or Dates: 14. Race - American Indien, Bieck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ ¥₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglena. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hyglens Important: If flem 27 is marked other that eny linjury or other traumatic event, trau pages. 12 Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Be Wilbur J. Wayson Clara Wayson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8 Idlewood Street, Glen Burnie, MD 21061 Wayne Chaney - Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Surial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) Glen Haven Mem. Pk. 5/17 Glen Burnie MD Funeral Service Lig 22. Neme end Address of Fecility Fink Funeral Home, PA 21. Signet Helly Gregory Fink 426 Crain Hwy., SW, Glen Burnie, MD 23e. Pert1. Enter the disease, of somplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in deeth) INERIOR 9 hours Acuti WALL Examiner Due to (or es a consequence of): Examiner CAD burial-transit requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): and sttending physician for use as the buria Box 68760. Physician/Medicai Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. the signed by t 1 2 Yes 2 No 3 Probably 4 Unknown COLON LIVER MITH METASTAGES Records, by 24b. Were eutopsy findings eveilable prior to completion of cause ot death? 24a. Wes en eutopsy performed? Completed peen page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient ∴ 2 ER/Outpetient 3 DOA funeral 28d. Describe how injury occurred Medical Certification: 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After t or Attending 5 Pending investigation 1 Neturel To the Hospital or Attending within 24 hours after death.

To the Funerat Director; After completely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) end menner steled. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number 05/13/2000 113472 m.D. 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) SAMDER HARBOR HOSTITUL, POALTIMORE GAUTAM

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Dev. Year)

MAY 1 7 2000

oouto

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 15760

					Ce	rtificate	e of	Death			Reg. No.	0 1	3700		
	1. Decedent's Name (First,	Middle, Last)								2. Date of D	eath		3. Time of Death		
Physician	BEVERLY A	NE CII	MMTNGS							Month MAY	13,	2000	1737 PM		
/Medical Examiner	4a Facility Name (If not insi							4b. City, To	own, or L	ocation of Dea		unty of Deat			
LAditilier	ST. JOSEPH'S	HOSP	ITAL					TOW	SON		E	BALTIM	ORE		
Funeral	5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of B (Month, D		9. Birt	hplace (State or Foreign		
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alf. or	3 ☐ Widowed 4 ☐ Div		If Yes, Gi	V8		1□ Yes 2	2 XNo	Specify			Sp	ecify:	WHITE		
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/Medical Examiner	Immediate Cause (Final disease or condition		Hyper	tensive	Arter	ioscl	ero	tic C	ardi	ovascul	ar Dis	ease			
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Registrar DHMH 16 Rev 6/95

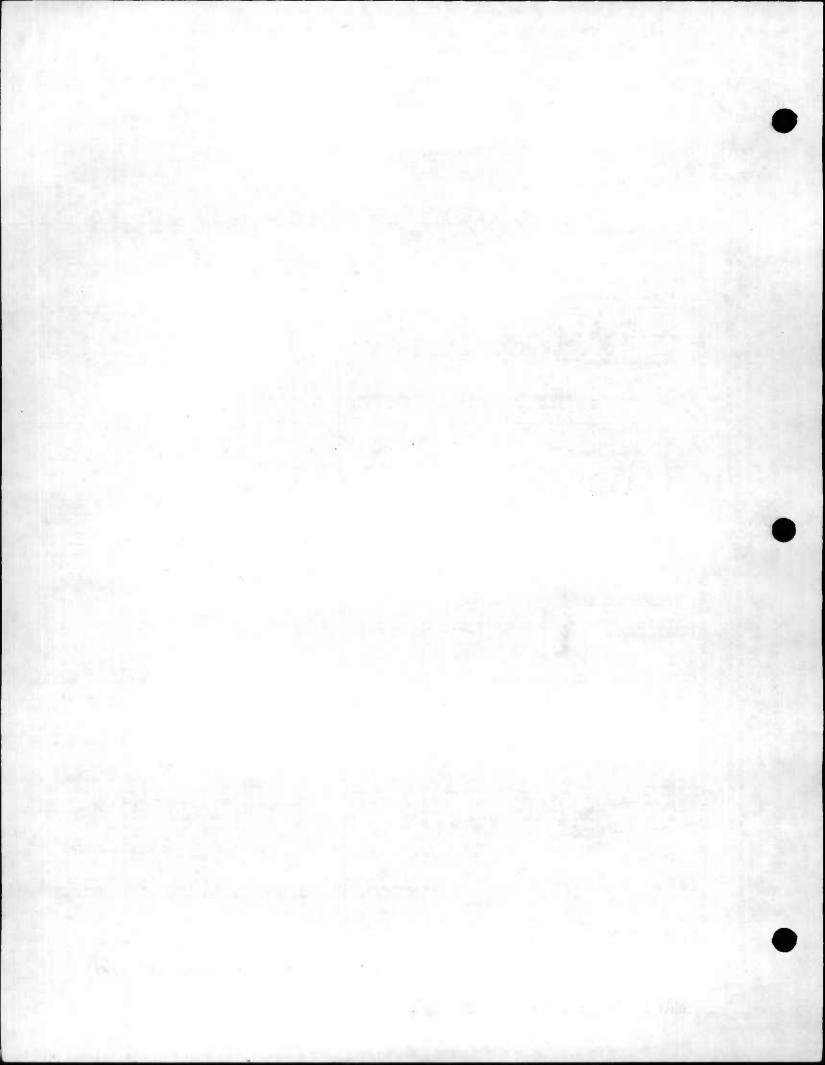
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death 10^{Day} Ma Wonth **Physician** 20000 2:20 PM Verna E. Dishman /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 ☐ M 2 🗓 F 91 Yrs. 219-10-9911 Director Jan. 11 1909 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itema 23s or 28s-f show traumatic avent, the Medical Examinar must be notified at 1 Yes 2 No Director Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 7728 Alpine Beach Road USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Hem any Injury or other traumatic event, the secure of the 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufactoring 17. Father's Nema (First, Middle, Last) 18. Mother's Nema (First, Middla, Meidan Surnama) 8 Albert Griffen Annie Kratz 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 7728 Alpine Beach Road, Pasadena, MD. 21122 Cherie Briggs(grandaughter) 20b. Place of Disposition (Name of cemetery, cremetory or other 20a. Method of Disposition 20c. Location - City or Town, Stata May Date 3 Loudon Park Cemetery 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 2000 21. Signature of Funeral Service & 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, Md. 21122 23a. Part1. Enter the disease, or complicate shock, or heart feiture. List only one ons that caused the death. Do not enter the mode of dying, such as cardiec or raspiratory arrest, Approximata Intervel Between Onsat and Daath **Physician** SSARATOKY FAILUKE Immedieta Cause (Finel diseasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner physician and s the burlal-transit The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ata has been signed by page 2 should be detac 1 Yee 2 No 3 Probably 4 Unknown Paiou Smoot Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? is certificate h 2 No 1 Tas 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director; to 25. Was case referred to medical 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 25 No Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Hatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide to the best of my knowledge, death occurred at the time, date end place, end due to the ceusa(s) and menner es stated.

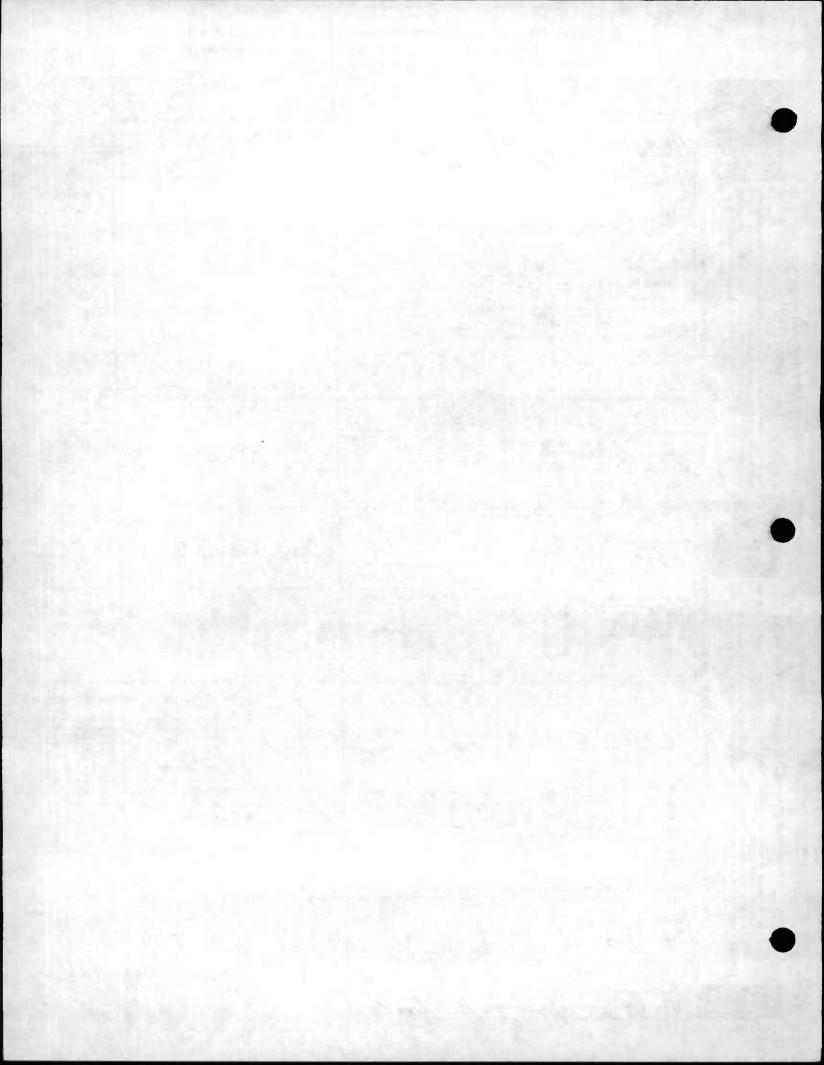
| Continued on the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier (Check only 29b. Signature and little of certif 29c. License number 29d. Data signad (Month, Day, Year) 5/12/60 123-142 uun and address of person who complet cause of death (Item 23a) (Type, Print) N KRIMINS 104 RIDERDY MU 31. Data filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 7 2000 Registrar



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State of Maryland / Department of Health and Mental Hygiene 00

	Certificate of Death	Reg. No.	15/62
Physician	1, Decedent's Nama (First, Middla, Last).	2. Data of Death Month Dey Ya	ar 3. Tima of Death
/Medica	11111111 July 120015	11/ay 12,20	00 JOSAM
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Director	817-04-0099 14 1 201 70 Hs.	MAKC173, 1960 11	raryland
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- 203.44	270 FREBHILTON	PASS Balfo., mi	5. 21229
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the Ho in 24 the Fu pletel	(Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occur and mannar stated.	(21 X	
with Tool	29b. Signature and title of certifier 29c. Licensa number CO 2 0	29d. Data signad (A	() c)
\sim	30. Name and address of person who completed cause of death (flam, 23e) (Type, Print)	5/15/	100
	Juseph Pallan, M. D. 10 Mary and Git.	neral Hos	ortal
State	31. Data filed (Month, Day, Year) 32. Registrer's Signetura		
Registrar	MAY 17 2000 perever B. sports		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** POSTLE) EVANS KOBERT 10:50 pm May 13,2000 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) 10M 20F 3 5.C. 219-50-3040 3-18-194 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ØYes 2 □ No Funeral Director HOWARD COLUMBIA 10f. Zin Code 10g. Citizen of Whet Country? 10e Street and Number 5402 WoodEd USA WAY 21044 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stelus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BETH-EL TEMPLE Elementary/Secondary (0-12) College (1-4or 5+) PASTOR Church of ChrisT, INC 2 4RS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ROBERT EVANS ETHEL MAE CHARLES SR 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) WAHSEEOLA EVANS 5402 WOODEA WAY COLUMBIA MO 21044 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 PBurial 2 □ Cremation 3 □ Removel from Stete 5/22 BALT. MD ARBUTUS PK 4 ☐ Donetion 5 ☐ Other (Specify) MEM. 00 22. Name end Address of Fecility FUNERAL HOME 21. Signature of Funeral Service Licenses 21213 BETTS omary CAROLINE ST BALT MD 1129 23a. Part / Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heer failure. List only one ceuse on eech line. Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) NEDIAR AMHEUND Due to (or es e consequence of): Physician/Medical Examiner ALLUNE 00 JE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): WETASTADI Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 2 NO 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Deeth (Check only one) Medical Certification: To Be Hospitel: 1 Appatient 2 ER/OutpatienI 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes > No 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 1/2 Natural 2 Accident 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Thomicide

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the Medical Examiner must be notified at

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Maryland 21215-0020

Baltimore,

Vans

The law requires that the death certificate be axecuted Physician: s after dec. al Director: After Attending Division 6

To the Hospital of within 24 hours a To the Funeral D

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year) 2000

29b. Signature and title of certifier

arrivo

29e. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DICKE MO

6701 32. Registrar's Signature

DICKE, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner steted.

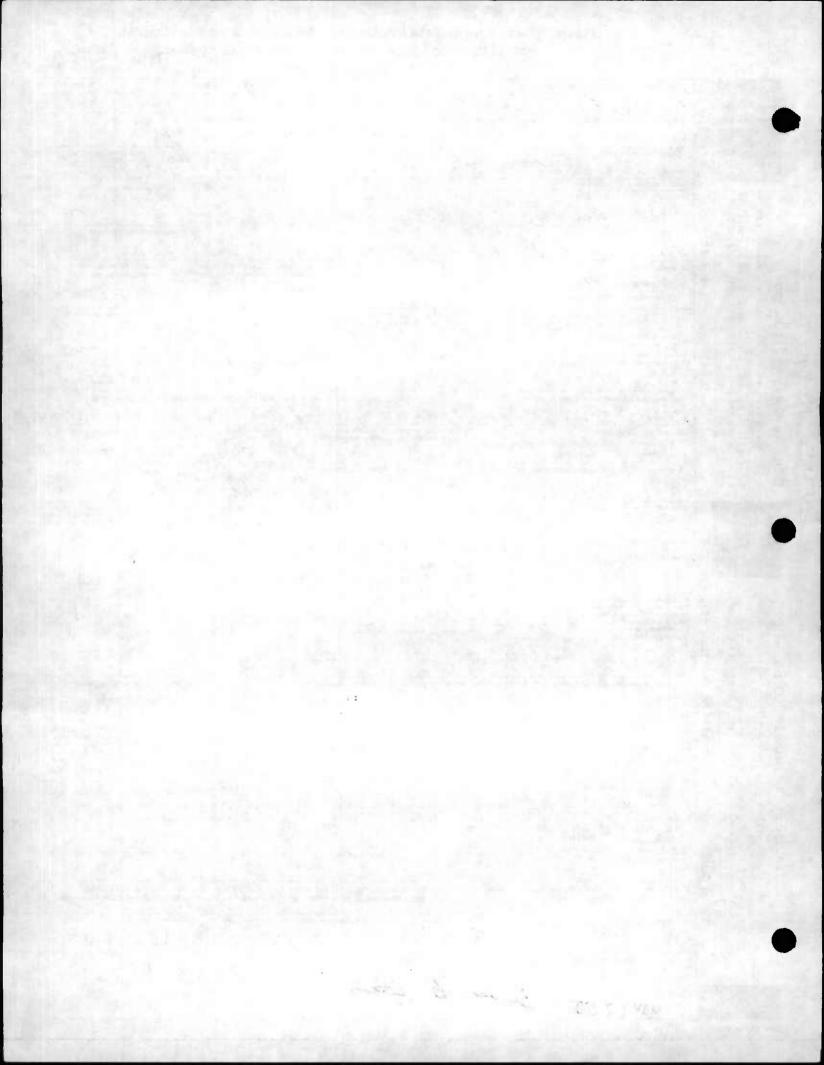
29c. License numbar

D 36231.

CHARLES ST STUF YIOS BACTO MD 2124

29d. Date signed (Month, Dev. Year)

14,2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 3. Tima of Death 2. Data of Death Month Anna Alva Flagg 11 2000 9:00 AM May 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 2229 Christian Street Baltimore n/a If Under 1 Yaar Months Days 8. Data of Birth (Month, Day, Year) Oct 27, 19 If Undar 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foraign Country) Months Hours 1 M 2 F Yrs. 214-24-1064 78 1921 Maryland Usual Residence of Decedent 10a Stata 10c. City. Town or Location 10d. inside City Limits 10b County tX Yas 2 □ No Maryland Baltimore n/a 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21223 2229 Christian Street U.S.A. Was Decadant of Hispanto Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: White Specify: If Yas, Giva Yaar or Datas: 3 ☐ Widowad 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Brush Company 10 0 Brush inspector 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) William Dennis McClelland Anna Chatterton 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3113 Ryerson Circle, Lansdowne, Maryland 21227 Tim J. Lewis / son 20b. Place of Disposition (Nema of cematery, crametory or other place) 20a. Mathod of Disposition Data 20c Location - City or Town State 1 ⊠Buriel 2 □ Cramation 3 □ Ramoval from Stata 5/16/2000 Baltimore, Maryland New Cathedral Cemetery 5 Othar (Specify) Signature of Funeral Service Licens 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc.
4107 Wilkens Avenue, Baltimore, Maryland 21229

Part: Entar tha diseasa, or complications that causad the deeth. Do not enter tha moda of dying, such as cerdiac or raspiratory arrast,

Approximata

Physician /Medical Examiner

attanding physician

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certificate

After this

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

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certificate be execu Box 68760.

P.O.

Records.

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Mexical Examiner must be notified at

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Funeral

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important. If fem 27 is marked other the any injury or other treasment.

Saltimore, Maryland 21215-0020

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Examiner **Physician/Medicai** þ Completed Be 2 Certification:

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viac Due to (or as a consequence of):

Dua to (or as a consequence of): Dua to (or/as a consequence of)

Part II. Other eignificant conditions contributing to death but not resulting to the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 20 No 3 Probably 4 Unknown

24a. Was en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

Approximata Interval Between Onset and Daath

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1 Tas 2 No 1 ☐ Yas 2 No

25. Was cesa referred to medicel axaminar? 26. Placa of Daath (Chack only ona) Hospital: Othar: 4□ Nursing Homa 5□ Residence 6 □ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28b. Tima of 28d. Dascribe how tnjury occurred

29c. Licansa number

36 900

28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Panding invastigation 1 Natural tnjury 1 ☐ Yas 2 ☐ No 2 Accidant 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homtcide

29e. Cartifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the causa(s) end menner as stated.
20 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, dete end place, and dua to the ceuse(s) and mannar stated.

29d. Data signad (Month, Day, Year)

4

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 415 Crain Highway SE Glen Burnie, Maryland 21061 Dr. Krishan Singal

State Registrar

DHMH 16 Rev 6/95

edicai

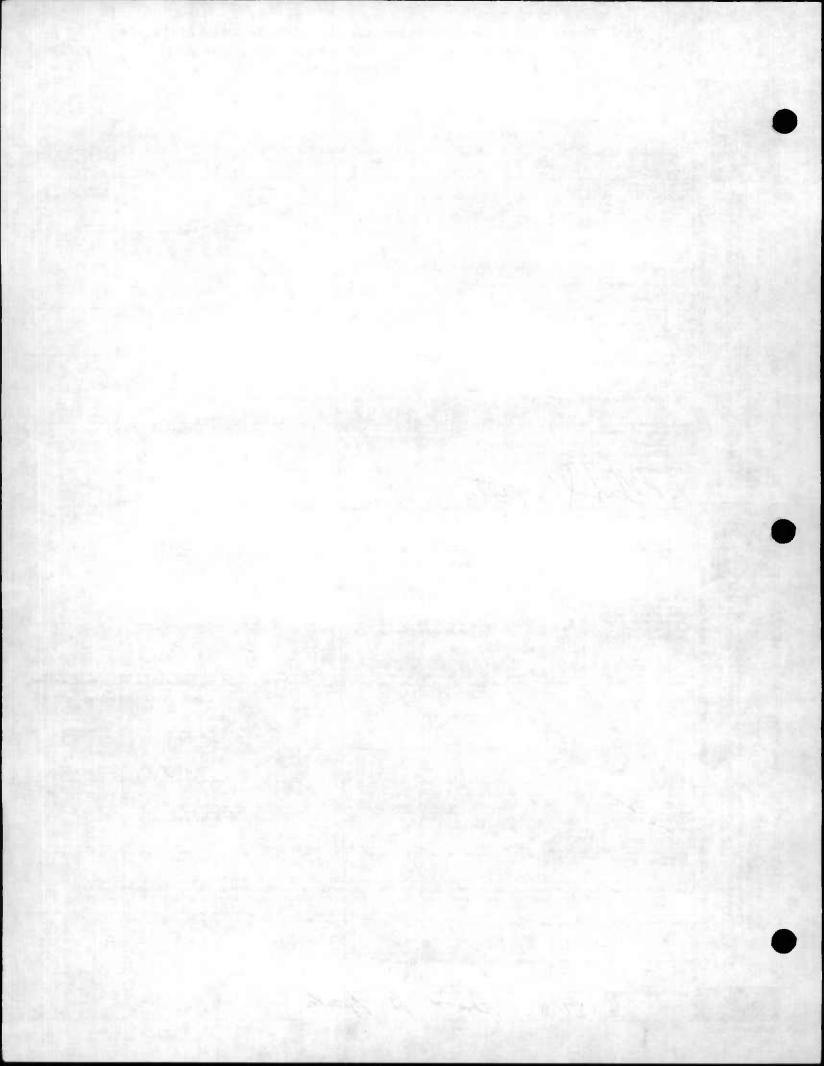
31. Data filed (Month, Day, Year)

29b. Signature and titta of certifier

32. Registrar's Signatura

Disease Towns on Dalach in Disease Installible Inde	
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygien	5765
Cartificate of Dooth	

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Dhaminin	1. Decedent's Name (First, Middle,	Last)	2-11-12					2. Date of De Month	eth Day	Year	3. Time of Death
Physician /Medical	Glibert			owers				May 1	1, 2000)	2:00 AM
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Funeral Director	5. Social Security Number 219-30-5438 Usuat Residence of Decedant	Sex 7. A	ge (In yrs. last b	Yrs. If U	nder 1 Year iths Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Mar.	th 17,1934	Coun	olaca (Stete or Foreign ntry) rginia
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Example Fundamental	3√ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 20 If Yes, Give Year or Dates:	?		ecedent of H specify Cub	lispanic Ori an, Mexicar Specify:	gin? (Sp n, Puerto	pecify Yes or No Rican, etc.)	14. Raca - American Indien, Black, White, atc. Specify: White		atc.
leted	15. Decedant's (Specify only highast) Elemantary/Secondary (0-12)	Education grade complated) College (1-4or	5+)	a. Decedent's (Give kind of life. DO NO	Usual Occup of work dona OT use retire	pation duning mos d)	t of work	king	16b. Kind of Bu	usiness/Ind	dustry
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r traum	19e. Informant's Name/Relationship								er, City or Town,		
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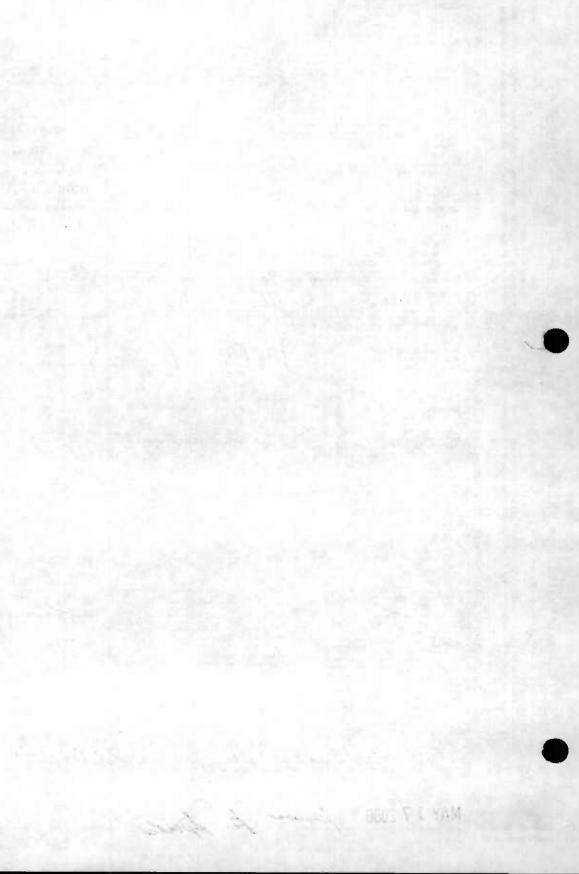
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State of Maryland / Department of Health and Mental Hygien

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month 05 -30 AM **Physician** KENNETH T. GRANT 10-/Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner NIA POINT NURSING & REHABILITATION CTR. RALTIMORE If Under 1 Yeer Months Deys If Under 24 Hrs. Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 10/M 20 F Hours 217-66-8439 30 MD Director Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits 10a State 28s-f show the Medical Examiner must be notified at 1 Ves 2 No NIA Funeral Director BALTIMORE MD 10e. Street and Number 10f. Zio Code 10a. Citizen of Whet Country? ò ROAD 21215 USA DORITHAN 3301 or items 23s filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca · American Indien Bleck, White, etc. 11. Merital Stetus 1 Never Merried 2 ☐ Merried 21215-0020 1 Yes 2 No Specify Specify: BLACK Be Completed by t Yes, Give Yeer or Detes: 3 Widowed 4 Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mentel Hygiene. Elementery/Secondary (0-12) ADMIN ISTRATOR DEPT. SOCIAL SERVICE YRS 12 TH GRADE Saitimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mentel JAMES GRANT MARY LEACH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau MARY LEACH BALTO. MO. 21215 MOTHER DORITHAN RD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Methød of Disposition 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from State GARRISON FOREST 5.18.00 OWINGS MILLS, IND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATI PIKE, BALTO. MO . 21229 23a. Pert1. Enter the diefese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in deeth) √Medical Examiner Due to (or es e consequenca of): Physician/Medical Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequenca of): Box 68760, thet initieted events resulting In deeth) Lest Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 40 Unknown Division of Vitai Records, þ page 2 should be 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed this certificate hes 1 ☐ Yes 20 N al or Attanding Physician: The safer deeth.

If Director: After this certificated in by the funeral director, pi 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Medical Certification: To 28e. Date of Injury (Month, Dey Year) Injury et Work? 28d. Describe how Injury occurred 27. Menner of Deeth 5 Pending Investigation 1 Vaturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D Tillying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed/(Month, Dey, Year) 29b. Signature and title of certifier d address of person who completed cause of deeth (Hein 23a) (Type, Print) 1 AY 1 7 2000 MAY 32. Registrer's Signeture State Registrar



Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 -400 pm BROWN UZIVIN 10 4a Facility Name (II not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death N/A BLAND AVENUE RALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 10M 20F Months 16-18-6144 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Ves 2 No NIA MO BALTIMORE 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21215 USA 5706 BLAND AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 11 Merital Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 VRS LPN CARE HEALTH 2 TH GRADE 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) LILLIAN BURTON QUITMAN BROWN 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WINSTON GRAY 2683 PARK DR. BALTO. MO. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State PARK CEMETERY 5-16-00 RANDALLSTOWN MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATI PIKE, BALTO. MO. 21229 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dreumonia 2 day disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1□ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennes of Death 1 Netural 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

signed by the a Records, The law requires cate has been significant page 2 should b of Vital

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Example page.

Physician 7Medical

Examiner

physician and the burial-transit

9SN

Examiner

Physician/Medical

ρ

Completed

Be

edical Certification: To

2 Accident

4 THomicide

29b. Signature and title of certified

3 ☐ Suicide

29a. Certifier (Check only one)

Baltimore, Maryland 21215-0020

the Marviand

certificate this To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the tunera After t Division

Registrar

State

Rothschild 4000 Elliot MAY 1 7 2000 32. Registrar's Signature

6 Could not be

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) old Court

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Pikesville Rd 2 mp

1 Yes 2 No

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

1208

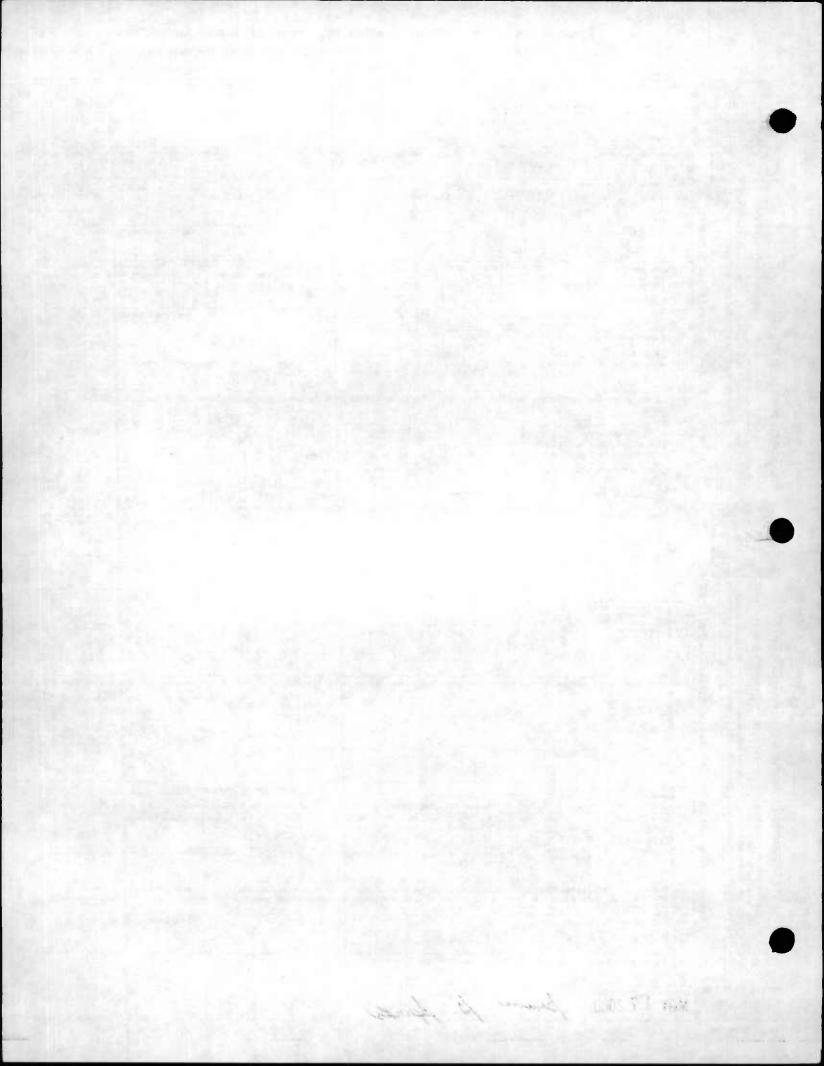
May

28f. Location (Street end Number or Rurei Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

2000

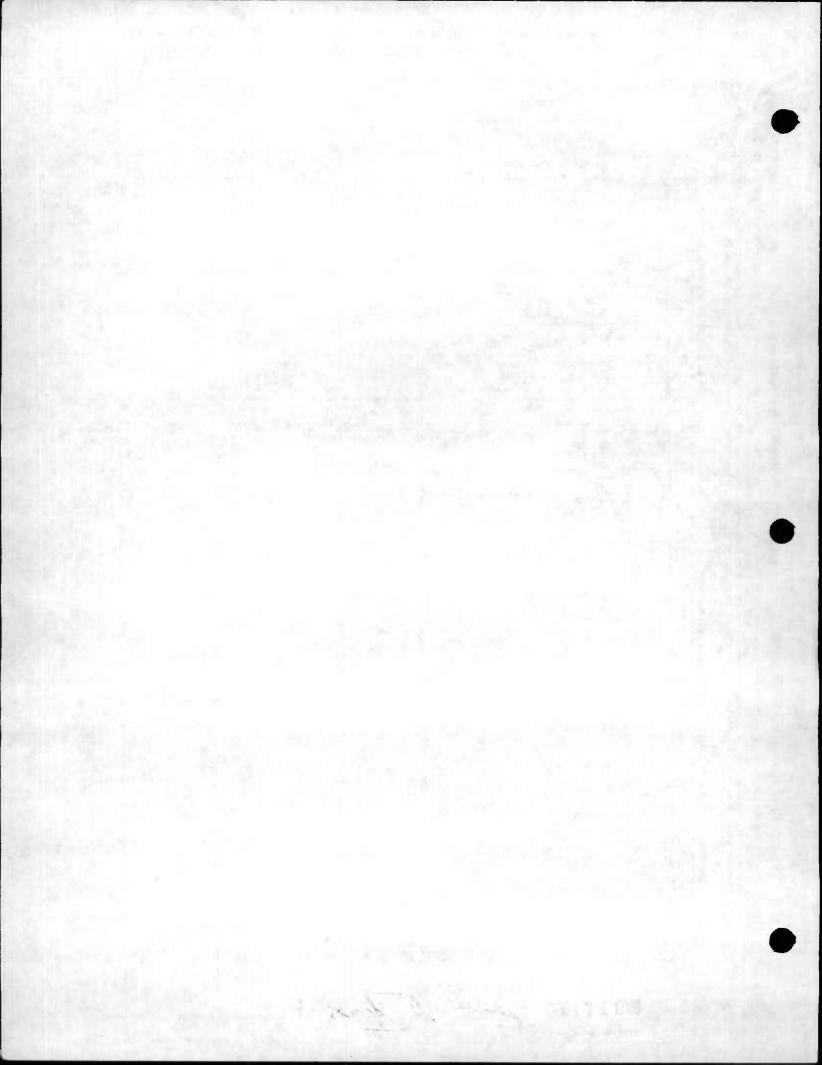
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.K.S OSEPH G		KI			larylan	d / Depa		lealth and	•	ygiene	15768	
AMEND		MS : 23B 1. Decedent'a Nar		G783 5-25	5-00 V	IR. Cer	illicate of	Death	2. Dete of D	Reg. No.	3. Time of Death	
Physic				Sinski, Jr.					Month MAY	13, 2000	Yeer	
/Medi Exami				give street and number)			4b. City, Town, or	Location of Dee			
V				BAYVIEW MED				BALTIM				
Funeral Director		5. Sociel Security 216-42-0 Usual Residence	0037		ge (In yrs. i	ast birthday) Yrs.	Months Deys	If Under 24 Hrs Hours Min	8. Dete of B (Month, D 07-22	inth Pay Year) -1944	Birthplaca (State or Foreig Country) MD	
Mend wo		10a. State	10b. County		10c. City	, Town or Loc	ation				10d. Inside City Limits	
- Man	io	MD	n/a		Balt	imore					1 X Yes 2 □ No	
or 28	Director	10e. Street and N					10f. Zip Code			10g. Citizen of	Whet Country?	
ath w			Clinton				21224		USA			
72 hours effer death with the Maryland naturel', or fferm 23a or 28a-f show steel Frantiner must be notined	by Funeral		rried 2 Marrie	12. Wes Decedent Armed Forces 1 Tyes 2 If Yes, Give Year or Detes:	? INO Vie	etnam 1	/as Decedent of I Yes, specify Cub	Hispanic Origin? (lan, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	Specify	e - American Indien, ck, White, etc. White	
n 72 hours	eted	(Spe	15. Decedent'	s Education t grade completed)		16a. Deced	ent's Usuel Occu	pation during most of wo	rking	16b. Kind of B	usiness/Industry	
within ene.	Completed	Elementery/Sec		College (1-4or	5+)		<i>o Not</i> use retire worker	d)		teel		
Hygie The		17. Father's Name	(First, Middle, L	1 -		Steel	worker	18. Mother's Na	me (First, Middle	Beth. S		
Mentel Mentel of arked of artice even	o Be			Ginski, Sr.				Leocayd				
th end th end to m		19a. Informant's f								rel Route Number, City or Town, State, Zip C , Baltimore, Marylan		
permit. Peges 1 en Department of Heal Important: If Item 2 any Injury or other pncs.				3 □Removal from Stete	20b. P	ace of Dispos	ition (Neme of electron other ple	oce)	5-16-00		City or Town, State Ore, MD	
permit. Departminporta		21. Signature on	uneral Service L	icensee	cki			ess of Facility I Funera Ik Avenu			aryland 21222	
Physician /Medical Examiner		Immediate Cause disease or conditi resulting in death	(Final	Arteric	scler		ardiovas	scular Di			Onset and Deeth	
deeth cartificate be executed e attending physician and of for use as the burial-transit	Physiclan/Medical Examiner	Sequentially list c if any, leading to i cause. Enter Unc Ceuse (Disease of that initieted even resulting in death)	derlying or Injury its	b		as a consequ as e consequ						
es thet the deeth cer igned by the attendir be detached for use	Physicia	Pert II. Other sign	ificant condition	ns contributing to death I	but not resu	iting In the un	derlying cause gi	ven in Pert I.		d tobacco use co	ontribute to the cause of deat	
The law requirate hes been spage 2 should	Completed by						4		INSF	s en eutopsy formed? PECTION Yes 27 No	24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yes 2 No	
Physician: The this certificate ral director, pe	Be	25. Was case refe examiner?		Hospitel:			on so. Ot	her.	eth (Check only		(D. V.)	
ath. r: After	ation: To	27. Manner of Dee XXNatural 2 Accident	5 Pending	28a. Date of Injury (Month, De	ury	ER/Outpatient 28b. Time of Injury	28c. Inju	4 Li Nursing	_	sidenca 6 □Oth e how Injury occur		
tal or Attendent rs after deat al Director: led in by the	Certification:	3 ☐ Sulcide 4 ☐ Homlcide	6 Could no determine	ned 288. Placa of In								
To the Hospital or Atle within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier (Check only one)	XX Medical E	Physician: To the best end manner s	of examinet	vledge, death ion end/or inv	estigation, in my	opinion, deeth occ	a, end due to the urred at the time	e, dete end place,	end due to the ceuse(s)	
Tot	2	29b. Signature en	d title of certifier	9-1				se number .C.M.E		29d. Date signe MAY	13, 2000	
					death (Item							

DHMH 16 Rev 6/95

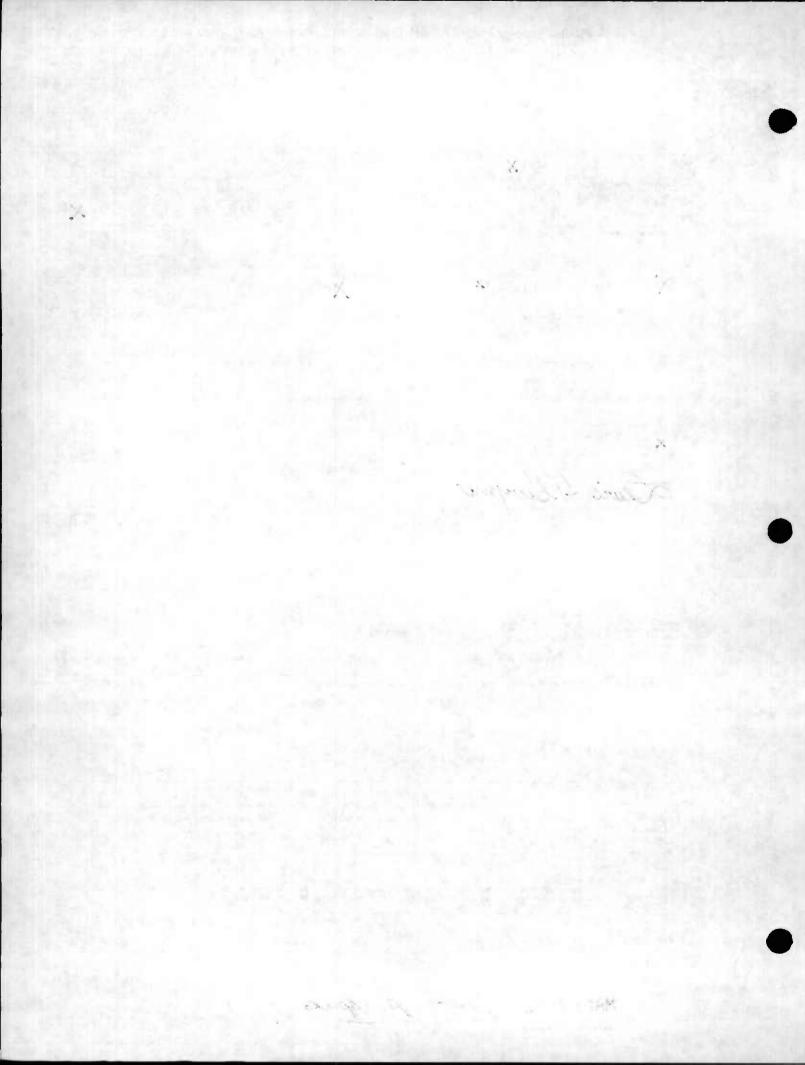
ORIGINAL



00-2598-510 Alic JVW

		State of Mar		ertificate of		Re	g. No.	15/69
Obvoicion	1. Decedent's Name (First, Middle,	Last)				2. Data of Death	Day Ye	3. Time of Death
Physician /Medical	ALICE	GAYMON				May 09.2	200	05:40 P
Examiner	4a Facility Name (If not institution, g 813 North Payson				Baltimor		4c. County of D	N/A
uneral	5. Social Security Number 6.		'In yrs. lest birthday	Months Days		8. Date of Birth (Month, Day.	Year) 9.	Birthpiaca (Stete or Foreign Country)
irector	219-38-6392 Usuai Residenca of Decedent	1□ M 2 % F	57 Yrs.					outhCaroli
show Male P	10a. State 10b. County		Oc. City, Town or I	_ocation				10d. Inside City Limits
28a-1 s notified rector	MD. N/A			Baltimo	re			1) Yes 2□No
0 8 0	10e. Street and Number			10f. Zip Code		10	og. Citizen of What	
s 23e mult prai	813 NORTH PAYS		enia II C	2122		No	U.S.A.	merican Indian,
or items 23. aminer must y Funeral	11. Marital Status 1 Never Married 2 Married	If Yes, Give	er in U,S. 13	ff Yas, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl Specify:	o Rican, etc.)		Vhite, etc.
d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						BLACK
A. the Medical Completed	15. Decedent's (Specify only highast (Secondary (0-12)	grede completed) Çollege (1-4or 5+)	(Giv life.	DO NOT use retir	e durina most of wo	rking	16b. Kind of Busine	
	12 th 17. Father's Name (First, Middle, La	N/A	DIET	ICIAN	10 Mathada Nas	ne (First, Middle, M	COOD SEF	RVICE INDUS
o Be								
T To	JAMES T. GAYMON		10h Mai	linn Address (Street	MARTI et end Number or Ri	IA WILDE		te Zin Code)
2 1	SALLIE PRETTYN				Y RD.BAI			
98	20a. Method of Disposition	IAN DIDIEN	20b. Placa of Disc	position (Neme of			20c. Location - City	
= 5	1 Burial 2 ☐ Cremation 3		cemetery, cri	emetory or other pl				
right.	4 Donation 5 Other (Special Service Lice	1			TAL PAR	5/15/00	ARBUTUS	MD
or sand	Lewis J	LEWIS	r.GWYNN	22. Nama and Add				NERAL HOM 21215-639
1.5	23a. Part1. Enter the disease, or co shock, or heert failure. List on	omplications at caused the	ne death. Do not e					Approximate Interval Between
sician edical	Immediate Cause (Final		Bubbby	halati				Onset and Death
miner	disease or condition resulting in death)	0.			on			1
<u> </u>		D	ue to (or as a cons	equence ot):				
ician and burial-transit	Sequentially list conditions	b	ue to (or as a cons	equence of):				
ician an burial-tr al Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							1
ysicia se bu	Cause (Disease or injury that initiated events	C	e to (or as a conse	equence of):				
nding phys use as the n/Medic	rasulting in death) Last	■ d						
to to	Pad # Other significant conditions	a contributing to death but	not reculting in the	underlying cause s	rives in Red I	23h Did to	hacco use contrib	oute to the cause of deat
ed by the detached	Part ff. Other significant conditions	s contributing to death but	not resulting in the	underlying cause g	jiven in Part I.			Probably 4 Unknow
80								
nsign ed blu						24a. Was a		4b. Were autopsy findings available prior to
s been s should						perform	ned?	completion of cause of death?
mp hes						1 D Y	s as No	1 ☐ Yes 2 ☐ No
- 0	25. Was case referred to medical				26 Place of De	ath (Check only on	O UNICES	10 100 20 100
S S	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ent 3 DOA				Specify) Scene
ertific ector.	I IDIANS ZIINO	28a Date of injury	28h Time	of / 28c. inj		7	w injury occurred	opcony) = = ===
his certific	1 X Yes 2 No 27. Manner of Death	(Month, Dey	(sar) Elajuty	14 45	☐ Yes 2/☐No	house	fre	
his certific	27. Manner of Death 1 Natural 5 Pending	tion 45 - OL 150			a	28f. Location (St	reet end Number o	or Rurel Bouta Number,
his certific	27. Manner of Death 1 Natural 5 Pending investigat 2 Accident investigat 3 Suicide 6 Could not	t be 28e. Place of Injury	/ - At home, farm, s			City or Town	, Stele) 8/3 A	V. Payson St
ector: After this certific by the funeral director, iffication: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	t be Ose Place of lains	(Specify)	home		13 Him	DY (1914)	/
Funeral Director: After this certific tely filled in by the funeral director, Ilcal Certification: To Be	27. Manner of Death 1	28e. Place of Injunbuilding, etc. Physician: To the best of taminer: On the basis of e	(Specify) my knowledge, dea xaminetion and/or i	home at the		a, and due to the ca		er as stated.
Funeral Director: After this certific tely filled in by the funeral director, Ilcal Certification: To Be	27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifiar 1 Certifying (Check only 25 Medical Ex	28e. Place of Injury building, etc. Physician: To the best of	(Specify) my knowledge, dea xaminetion and/or i	nome ath occurred at tha invastigation, in my		a, and due to the coursed at the time, do		er as stated. due to the cause(s)
he Funeral Director: After this certific pletely filled in by the funeral director, edical Certification: To Be	27. Manner of Death 1	28e. Place of Injunbuilding, etc. Physician: To the best of taminer: On the basis of e	(Specify) my knowledge, dea xaminetion and/or i	A ome ath occurred at tha invastigation, in my	r opinion, death occu	a, and due to the coursed at the time, do	ate and place, and 9d. Date signed (N	or as stated. due to the cause(s) Honth, Dey, Year)
Funeral Director: After this certific tely filled in by the funeral director, Ilcal Certification: To Be	27. Manner of Death 1	t be ed 28e. Place of Injunbuilding, etc. Physician: To the best of caminer: On the basis of e and manner state	(Specify) my knowledge, des xaminetion and/or i d.	ath occurred at tha invastigation, in my	opinion, death occi	a, and due to the coursed at the time, do	ate and place, and	or as stated. due to the cause(s) Honth, Dey, Year)
Funeral Director: After this certific tely filled in by the funeral director, Ilcal Certification: To Be	27. Manner of Death 1	t be 28e. Place of Injunbuilding, etc. Physician: To the best of taminer: On the basis of e and manner state Country To completed cause of das	(Specify) my knowledge, des xaminetion and/or i d.	ath occurred at tha invastigation, in my 29c. Lices Q.(nse number	e, and due to the coursed at the time, do	ate and place, and 9d. Date signed (No. 120)	or as stated. due to the cause(s) Month, Dey, Year)
Funeral Director: After this certific tely filled in by the funeral director, Ilcal Certification: To Be	27. Manner of Death 1	t be ed 28e. Place of Injunbuilding, etc. Physician: To the best of caminer: On the basis of e and manner state	(Specify) my knowledge, des xaminetion and/or id. J th (Item 23a) (Type	ath occurred at tha invastigation, in my 29c. Lices Q.(nse number C.M.F.	e, and due to the coursed at the time, do	ate and place, and 9d. Date signed (No. 120)	or as stated. due to the cause(s) fonth, Dey, Year)

ORIGINAL



Certificate of Death

3. Time of Death

Birthplace (State or Foreign Country)

White

21014

Approximete

10d. tnside City Limits

1 No Yes 2 No

Maryland

12:15 p.m.

Year

1. Decedent's Neme (First Middle Last)

Records. Division of Vitai

shock, or heert tailure. List only	one cause on each line.		1.10.1111.1.1.1.1		Onset end Death
Immediate Cause (Final disease or condition resulting in deeth)	DEMENTIA				
losulary in deeply	Due to	(or es e consequence of):			
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying	b. Due to	(or es e consequence of):			
Cause (Diseese or injury that initiated events resulting in death) Lest	cDue to	(or es e consequence of):			
	d				
Part It. Other significant conditions	contributing to death but not re	sulting in the underlying ca	use given in Pert t.	23b. Did tobacco use co	ontributs to the cause of death 3 ☐ Probably 4 X Unknow
				24a. Wes an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 X No	1 Yes 2 No
25. Wes case referred to medical examiner?			26. Placa of De	eth (Check only one)	
1 Yes 2 No	Hospitet: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐ DO	A Other: 4 Nursing I	Home 5 ☐ Residence 6 X Ot	ther (Specify) HOSPICE
27. Menner of Deeth 1 X Neturel 5 Pending 2 Accident Investigation		28b. Time of Injury M	3c. injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occu	red
3 Suicide 6 Could not to determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, street, fectory, cify)	office	281. Location (Street and Num City or Town, Stete)	ber or Rurel Roule Number,
29e. Certifier (Check only one)	hystoten: To the best of my kr miner: On the basis of examinand menner steted.	nowledge, deeth occurred e netion and/or Investigation,	ot the time, date end plece in my opinion, deeth occ	e, end due to the cause(s) end murred et the time, dete end plece	nenner es stated. , end due to the ceuse(s)
29b. Signeture and title of certifier		29c.	License number	29d. Dete sign	ed (Month, Day, Year)
12-		\mathcal{D}	43725	5/12	lev

Registrar **DHMH 16 Rev 6/95**

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TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

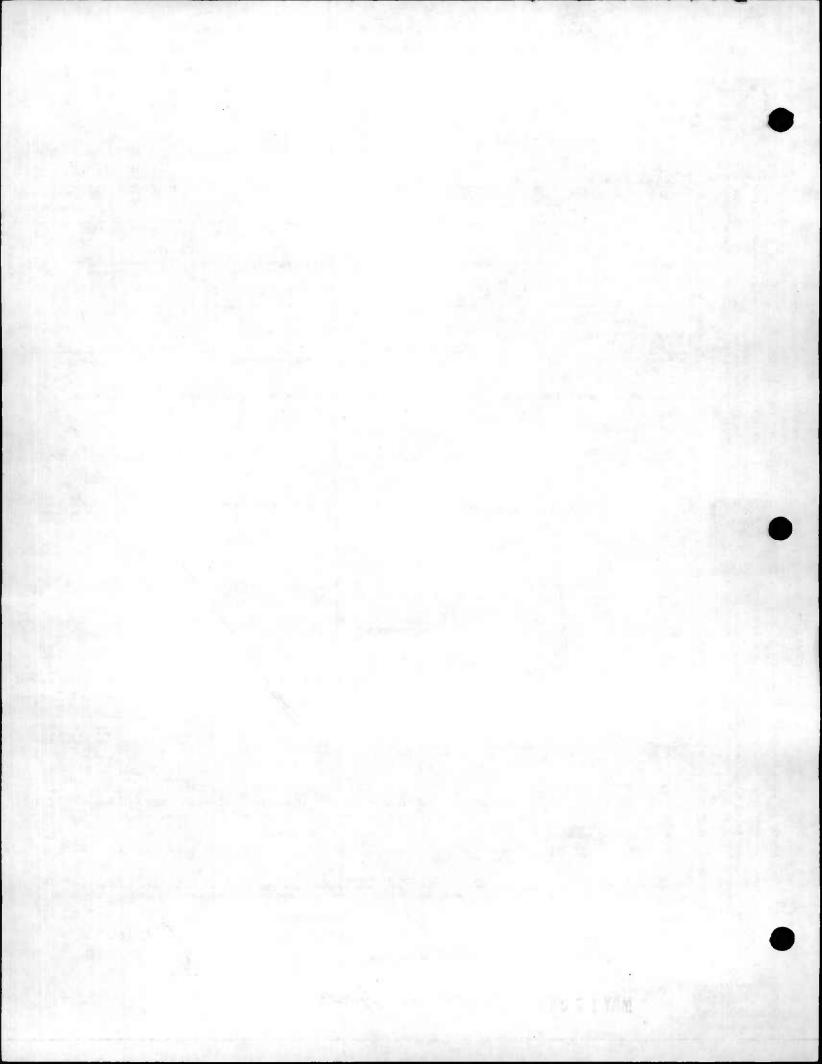
32. Registrer's Signeture

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

MAY 1 7 2000

31. Date tiled (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Tima of Death Day **Physician** 2000 PAUL GRAY 10:57A.M 4b. City, Town, or Location of Death WILLIAM 3 /Medical 4c. County of Death 4e Facility Neme (If not institution, give street end number) **Examiner** BALTIMORE OAKCREST MARKVILLE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 216-09-9434 Usuel Residenca of Decedant Yrs. FEB 2,1918 MARYLAND Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director BALTIMORE MIDDLE 10e. Street end Number 10g. Citizen of What Country? KINGSTON PARK LANE 21220 Nerna 23a 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Meritel Status pemit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or then any injury or other traumetic avent, the Medical Examinat page. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 210 No Specify: f Yes, Give Yaar or Datas: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 1 AUTOMOBILE MECHANIC Baltimore, Maryland 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be JAMES GRAY PARR ELLEN 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARY TAY LOR 20a. Method of Disposition DAUGHTER 62 W. KINGSTON PARK LANE BALTO, MD 21220 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removel from State GARDENS OF FAITH CEM. 5/17/00 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensea 22. Nama and Address of Facility FUNERAL ALTENBURG FUNERAL HomE, RA. 8, Outenburg Lic Dooco 2 6009 HARFORD ROAD BALTO, MD 21214 23e. Pert1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause of a ch line. Approximata Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition rasulting in death) /Medical Motustatic Prostate Cancer gears Examiner Due to (or es a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury Dua to (or as a consequence of): 68760. thet initieted events resulting in death) Last Due to (or es e consequence of) Box Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown f. brillation à 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes an eutopsy 1 Yes 24 No 1 Tyas 2 No of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 412 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No edicai Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menger of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Division 1 Neturel 5 Pending efter death. Director: Aff 1 Yes 2 No investigation 2 Accident William 6 Could not be datarmined To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted. 2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) end mennar steted. 29a. Cartifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar **DHMH 16 Rev 6/95**

State

5/13/00

8890 Watter Blud Bultinere MA 21234

30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print)

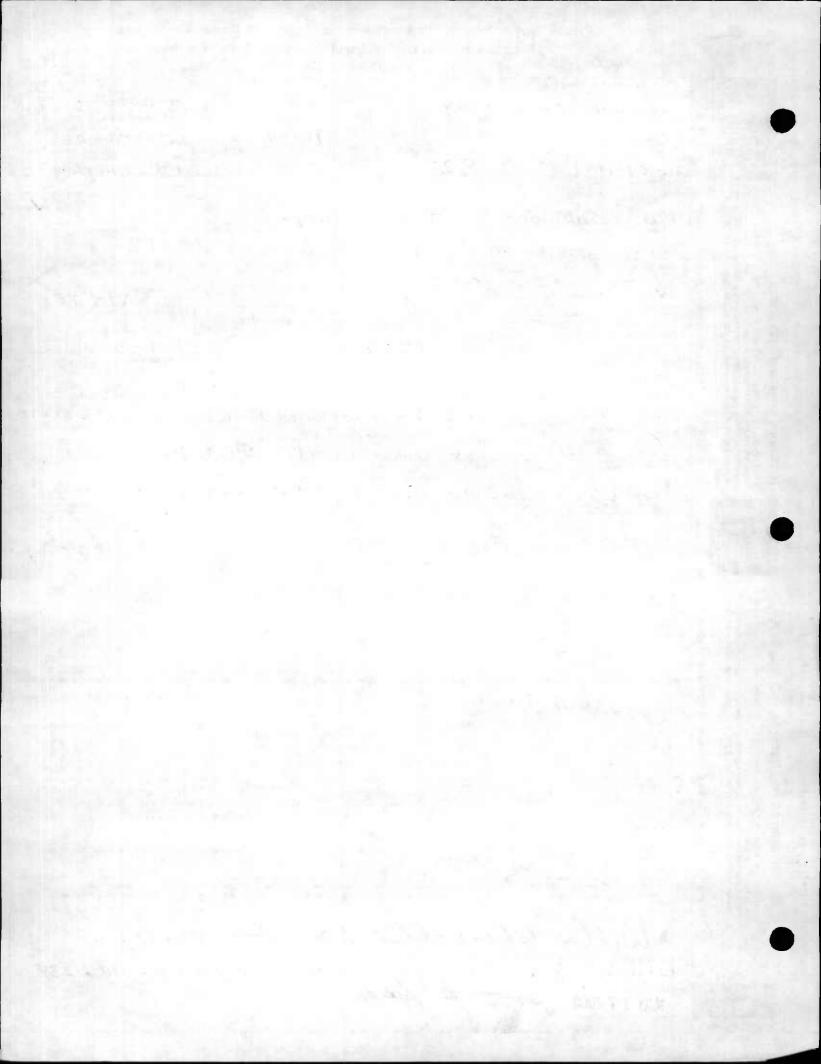
WILLIAM

31. Dete filed (Month, Day, Year)

MAY 1 7 2000

ussell

32 Registrar's Signatura



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Examiner NIA 120 ta 01 0 If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Social Security Number 6. Sex ge (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 F 217-66-3138 55 MP Director Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryla 28a-f short the Medical Examiner must be notified at 1 Yes 2 No NIA MD Funeral Director BALTIMORE 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? or Items 23a or 21229 119 N. AUGUSTA USA AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Merital Stetus filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1□Yes 2☑No Specify: Specify: BLACK Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondery (0-12) College (1-4or 5+) NA DISABLED 6 TH GRADE NIA ith and Mental Hygie 27 is marked other i r traumetic event, the 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be JOHN E HARLEE NOVAIL BALLARD 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health Important: If item 27 SISTER AVENUE, BALTIMORE, MO. HARLEE 719 N. AUGUSTA MILDRED 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State CREMATORY 5.17.00 4 ☐ Donation 5 ☐ Other (Specify) METRO BALTIMORE 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility CREMATION SERVICES 5151 BALTO. NATL PIKE. BALTO. MO au 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner should be detached for use as the buriel-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Di e to (or es e consequence of) Box 68760. attending physician 9 Physician/Medicai Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed uptial or Attending Physician: The law ours after death. eral Director: After this certificate has tifiled in by the funeral director, page 2 s 1 Tyes 2 NO 1 Yes 2 No 25. Wes case wife examiner Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Medicai Certification: To 1 Hes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and placa, end due to the cause(s) end manner stated. 29a. Certifier

To the Hospital within 24 hours a To the Funeral Completely filled

State Registrar

10u 6 31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

(Check only one)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print)

29c. License number

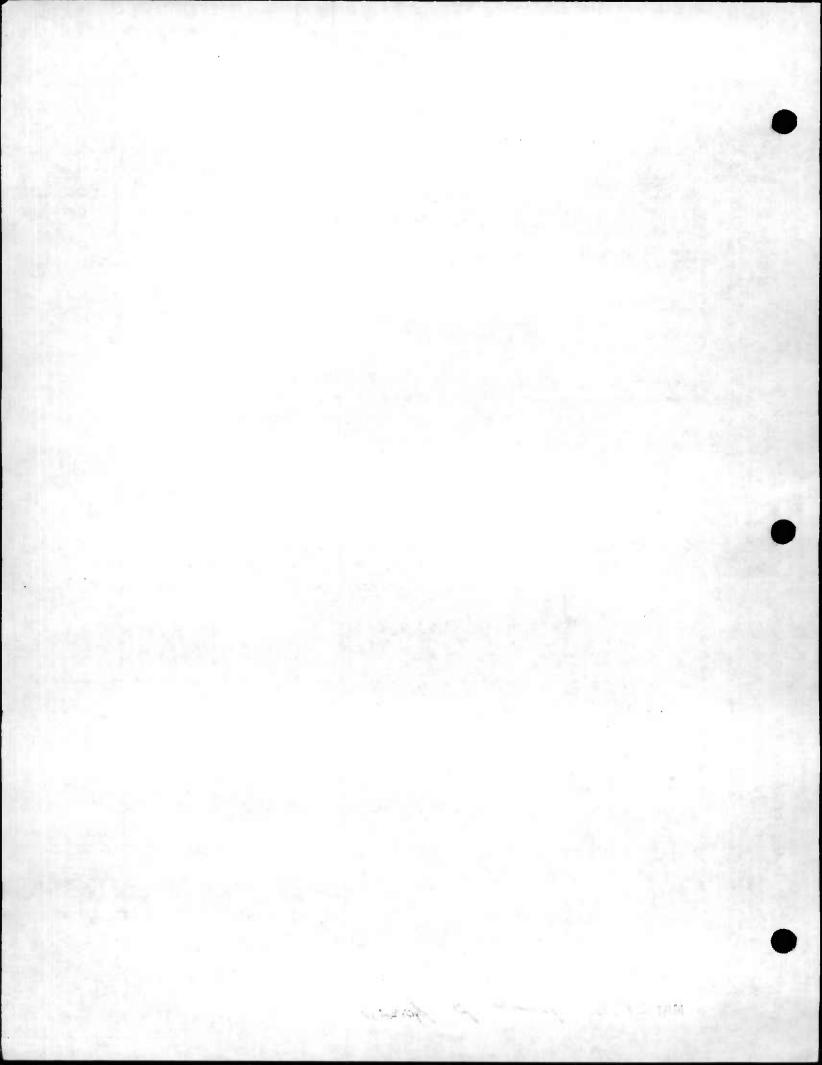
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29d. Date signed (Month, Day, Year)

2000

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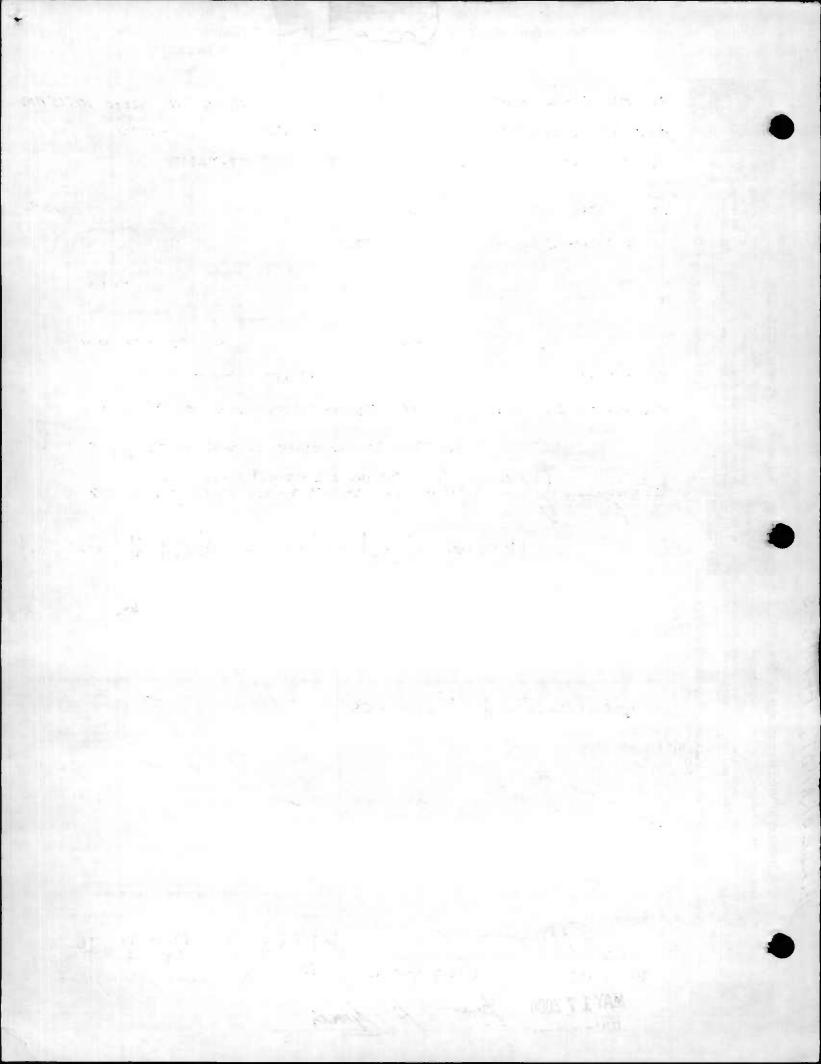
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie N Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death May Yaai **Physician** Frances Hildebrandt 10:15 AM // 2000 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, give street end number) 4c. County of Death **Examiner** Mariner Health Care Belair Harford If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. 1 Month Day Day 3 and Birthplace (Stata or Foraign Country) MD Aga (In yrs. last birthday) 5. Social Security Number **Funeral** 215-16-9413 1 □ M 2X F 89 Yrs. Director Usual Rasidance of Decedant the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exprising must be nothed and page. TV Yas 2 □ No Director MD Baltimore Baltimore 10f. Zip Coda 10g. Citizan of Whet Country? 10e. Street and Number 21224 617 S. Lakewood Avenue USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Decedant of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 □ Navar Marriad 2 □ Married Specify: White 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collaga (1-4or 5+) 0 Binder Paper Company 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be Frank Goralski Lillian Unknown 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, Steta, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) Mr. Kenneth Hildebrandt 1902 Cypress Drive, Belair, MD 21015-5806 20b. Place of Disposition (Nama of camatary, crametory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata St. Stanislaus Cemetery 5-16-00 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signeture of Funeral Service Licenses Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222 23a. Pert1. Entar the disaasa, or correlations that causad the death. Do not anter the mode of dylng, such es cardiac or respiretory errest, shock, or heart tailure. List or one cause on each line. Approximata Intervel Between Onsat and Daath **Physician** Immediata Causa (Finel diseasa or condition resulting In death) /Medical scular Accident Examiner Examiner Sequentially list conditions, if eny, leeding to immadieta causa. Enter Undarlying Causa (Disaasa or Injury that initiated avants Dua to (or as a consequence of) P.O. Box 68760 Physician/Medical Dua to (or as a consaquance of) 4 rasulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à Seizures Division of Vital Records, À 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performad? Completed 1 TYas 2 0 No 1 Yas 2 No certificate Be 25. Was casa rafarrad to madical 26. Place of Deeth (Chack only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 2 1 Yas 2 N 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 20 28b. Tima of Injury 27. Manner of Daath 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury el Work? Certification: 5 Pending Invastigation 1 Neturel 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) or A 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the best of axemination and/or invastigation, in my opinion, daath occurred et tha tima, data and place, and dua to the cause(s) and manner stated. edical 29e, Certifier 24 To the within 2 To the I 29b. Signature and title of certifian 29c, License number 29d. Data signad (Month, Dey, Yeer) 30. Name end eddrass of person who complated causa of daath (Item 23e) (Type, Print) 31. Data filed (Month, Day, Year) 2 32. Registrar's Signature State MAY 17 2000 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death ²2000 May 13, **Physician** Clarence J. Harrison 11:50 P.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 926 Dantrey Court Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Jan 15, 1935 6. Sex 1 M M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 215-32-2363 65 Yrs Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinar must be institled as Maryland N/A Baltimore 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2. and highly or other treumatic event, the Mester. 926 Dantrey Court 21225 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Detes White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Truck Driver 0 Purple Heart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be John William Harrison Hilda Florence Arnold 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) JoAnn Harrison (Daughter) 926 Dantrey Ct., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 Cremetion 3 Removal from Stete Oak Lawn Cemetery May 17,2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee Kevin E. Ecker 22. Nama end Addrass of Facility McCully-Polyniak Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart feilure. List only one ceuse on each line. Balto., Md. 21225-1856 Interval Between Onset and Deeth **Physician** Immediate Cause (Finat disease or condition resulting In death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner attending physicien end for use as the burial-transit The law requires that the deeth certificete be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initialed events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. Dua to (or es a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 Tho 1 ☐ Yes 20 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completaly filled in by the funeral director; to 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending invastigation 1 DNeturat 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

29b. Signeture and title of certifies

31. Date filed (Month, Dey, Year)

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32. Registrar's Signetura

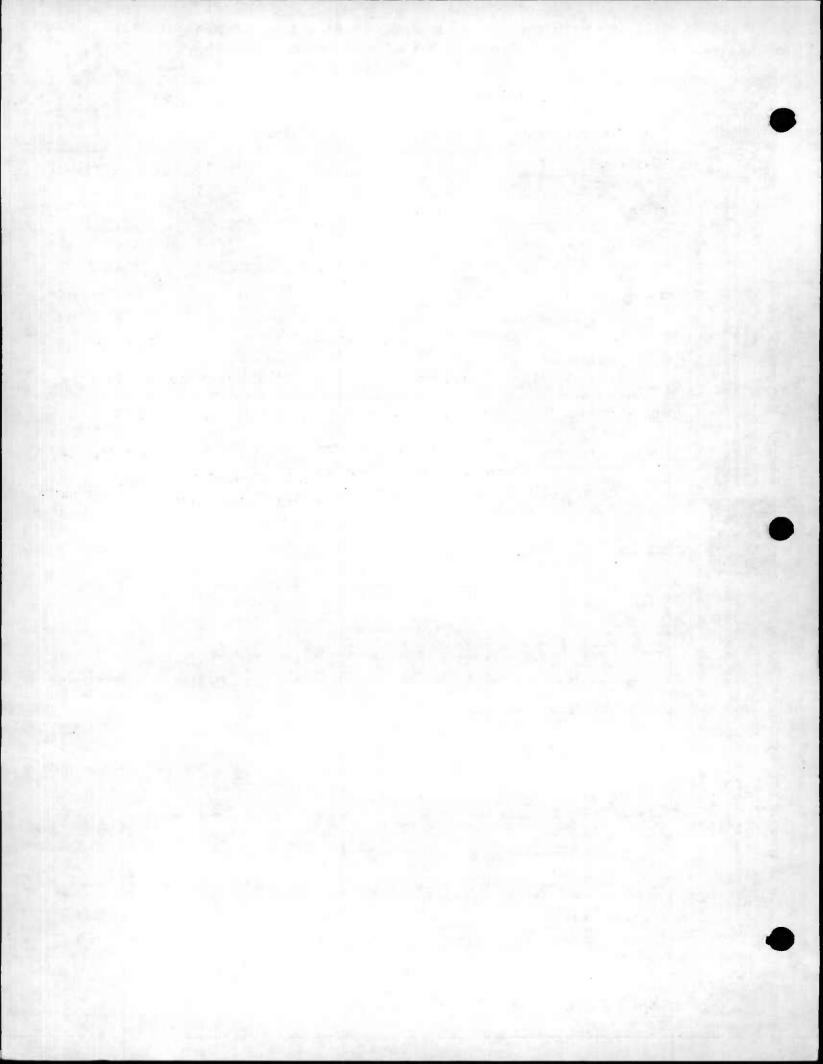
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29c. License number

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29d. Date signed (Month, Dey, Year)

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Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Hughes Mary 4c. County of Deeth 4a Facility Name (If not institution raive street and number City. Town, or Location of Da NA 8. Date of Bifth (Month, Day, Year) Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2□F 92 220-05-7803 02-20-08 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits NO Yes 2 No NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 21217 706 Newington Avenue USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamtress Chips N. Twigs Inc. 10th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Clark James 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121719a. Informant's Name/Relationship (Type, Print) 706 Newington Avenue Baltimore, Maryland Mary L. Armstead 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) New Cathedral Cem. 05-18-2000 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Baltimore, Maryland 21202 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WM.C.March FH 1101 E. North Avenue Approximate Interval Between Onset and Death tmmediete Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 Yes 2 No 24a. Wes an autopsy

Physician /Medical Examiner

Physician

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Box 68760.

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Division of Vital Records.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings aveilable prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 217No 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ONatural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 15 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

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29b. Signature and title of certified

31. Date filed (Month, Day, Year,

29d. Date signed (Month, Day, Year)

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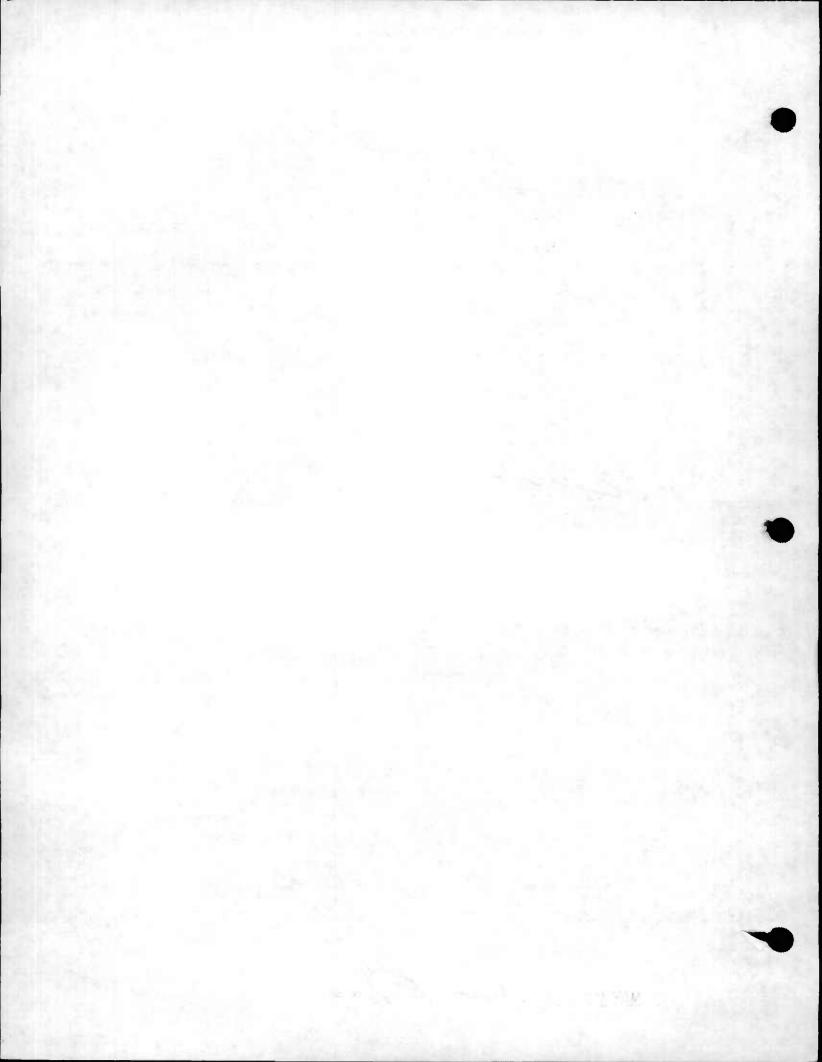
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Deta of Deeth 3. Time of Deeth Month Dey **Physician** Anna Μ. Hewing May 12. 2000 5:00 AM /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Genesis Cromwell Center Baltimore Baltimore | H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey. Yeer) | June 27, 19 9. Birthplece (State or Foreign Country) 1920 West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months 1 M 2 V F 79 Yrs. 232-24-8958 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow permit. Pages 1 and 2 should be filled within 72 hours after death with the Meryla Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f ahon any Injury or other treumatic event, the Heolical Examinal must be normed at 1 Yes 3 No Maryland Baltimore Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8636 Richmond Ave. 21234 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give 14. Raca - American Indien, 11. Merital Status Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White Completed by 3 Nidowed 4 Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) Collega (1-4or 5+) Public Schools Librarian 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Joe Chart. Sophia Cherry 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Mr. William B. Hewing, Jr. (son) 8636 Richmond Ave., Baltimore, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition ₩ Buriel 2 Cremetion 3 Removel from Stete 5/16/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cem. 22. Nama and Addrass of Facility
Schimunek Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensaa 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical EMENTIA Examiner Examiner DISEASE ONARY physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequenca of) Box 68760. Physician/Medical Due to (or es e consequenca of) 23b. Did tobacco usa contributa to the cause of death? P.0. ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed certificate has 1 Yes 2 No 1 TYPS 2 TONO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely lilled in by the funeral director; Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 28c. Injury et Work? 1 Neturel 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title gl-certifier 2000 05 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 3004, E MORTHERM PKWY. VIDULKERGAR, BHALDDIYA 32 Registrar's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** APRIL HAYLOCK JOSEPH + RANCIS 21,2000 0445 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRINCE GEORGES PRINCE GERRGES CHEVERLY HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. | Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2□ F 193-18-3211 LUNE 20, 1926 PENNEYLVANIA Director Usual Residence of Decedent the Maryland 10b. County 10a Stata 10c. City, Town or Location 10d. Inside City Limits 1 Yes No Funeral Director ST. MARY'S Md MECHANICSVILLE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 8 8 Lee Rd. 29868 22659 23# 1. S. A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status NO Yes 2 No If Yes, Give Year or Dates: W W II 1 Never Married 2 Married Baltimore, Maryland 21215-0020 matural, or 1□ Yes 20 No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) Delivery Driver Railway Express TI OC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be permit. Pages 1 and 2 should be in Department of Health and Mental important: If Nem 27 is marked of any Injury or other traumatic ever Joseph Havrock STELLA SILAK 19e. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LIAZEL RIVER Pol., KIXCYVILLE, Va. 22737 (Name of Data 206. Location - City or Town, Steta Addison Daughter 16229 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 128 Burial 2 Cremation 3 Removal from State MEM. CEM 4/25/2000 MAHASSAS, Va 4 □ Donation 5 □ Other (Specify) Tronewall 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BLASIUS- BAKER FUHERAL HOME Hornbaker 9320 WEST ST., MAHASSAS - Va. 20110 homas Approximete Intarval Batween Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MULTIPLE INJURIES WITH COMPLICATIONS Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera eutopsy findings available prior to completion of causa of deeth? 24a. Wes en eutopsy performed? Completed page 2 : 1 Yes 2 No 1 Tyes 2 No Division of Vital 25. Wes casa refarred to medical examiner? 1 D Yes 2 □ No Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 10 1♥ Inpatient 2 ER/Outpatient 3 DOA this. 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred DRIVER OF AUTO COLL ISION 27. Menner of Death 28b. Time of Certification: 28c. Injury at Work? Atter or Attending 1 Netural 2 Accident 5 Pending investigation 1209M after death. Director: Aft d in by the fur 02-28-2000 1 Yes 2 No 6 Could not be 28f. Location (Street end Number, or Rurel Route Number, MD City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide STREET ALLISON CIRCUEA COUNTY CAK RD To the Hospital Jething 24 hours To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signeture and

Registrar **DHMH 16 Rev 6/95**

State

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3001 HOSPITAL

(Item 23a) (Type, Print)

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29c. License number

29d. Date signed (Month, Dey, Year)

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MARTIN SON Jumes 19 House

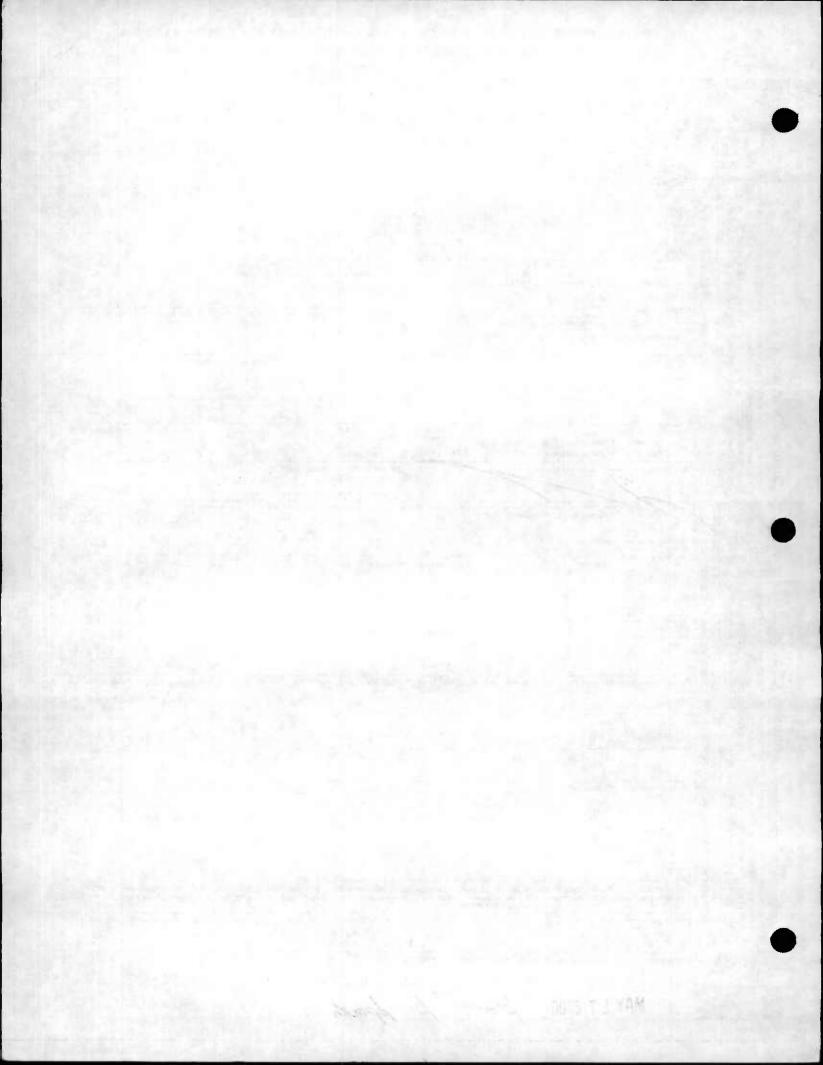
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** effr Opkins 10:20P.M 19-0 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number, Examiner BAITIMOF HOPKINS 7. Age (In yrs. last birthday) If Under 1 Year Johns If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Deys XXM 2DF Months 178-50-4792 Director 12/4/56 PENNSYLVANIA Usuel Residence of Deceden the Meryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow ital Hygiene. Id other than "natural", or frama 23e or 28e-f ahov event, tra Medical Examiner must be notified at 1 ☐ Yes 2 No Director CUMBERLAND CAMP HILL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Funeral 20 CEDAR CLIFF DRIVE 17011 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Meritel Status Black White etc. filed within 72 hours eftar 1 XYes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Account Rep. Benefits 4 YEARS 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill imant of Health end Mental Hant: If item 27 is marked oth Be other traumatic 2 JOHN G. HOPKINS, III JEAN NELSON 19e. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health er Important: If Item 27 is any injury or other trau 20 CEDAR CLIFF DRIVE
20b. Place of Disposition (Name of cemetery, cremetory or other place) WIFE ROSE HOPKINS CAMP HILL PA 17011
Dete 20c. Location - City or Town, State Baltimore, 20e. Method of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) EAST HARRISBURG CREMATORY 5/17/00 HARRISBURG, PA 21. Signature of Funeral Service Licenses 22. Name end Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Approximete Interval Between Onset end Deeth Page Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirelory errest, or heart feilure. List only one cause on each line. Physician Immediete Cause (Final disease or condition resulting in death) /Medical Leukemia Due to (or es a consequence of): Physician/Medical Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last ed by the ettending physician and detached for use as the burial-tran Due to (or as e consequença of): Box 68760. Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detact 2 No 3 Probably 4 Unknown 1 ☐ Yes à of Vital Records. 24e. Wes en eutopsy performed? Were autopsy findings aveilable prior to Completed completion of cause of death? After this certificate has 1 Yes 1 □ Yes 2 □ No Physician: funeral director, 25. Wes case referred to medicat Be 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? i or Attending P Division 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete-end place, end due to the ceuse(s) and menner steted. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5,2000 12000 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins, Baltimore Building Walker-Ford 110 TOWER 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture State MAY 1 7 2000 Registrar

DHWH

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month Mildred Coiner Hubbard 8:55 PM May 14 2000 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Augsburg Lutheran Home Baltimore Baltimore If Under 1 Yaar Months Deys 8. Date of Birth (Month, Dey, Year) August 22, 1905 5. Social Security Number If Undar 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) 1□M 2\ F Months Hours 224-01-2839 94 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street end Number 10f Zip Code 10g. Citizen of What Country? 230 Overbrook Road 21212 United States Rece - American Indien, Bleck, White, etc. Was Decadent Ever in U,S. Armed Forces? Wes Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No if Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Wldowed 4 □ Divorced White 15. Decedent's Education (Spacify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coilege (1-4or 5+) 5+ Eiementery/Secondery (0-12) Speech Teacher County Schools 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Eugene Coiner Unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Eugene Hubbard (Step-son) 230 Overbrook Road Baltimore, Maryland 21212 20b. Piace of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 🖾 Cremetion 3 ☐ Removel from State Green Mount Crematory 5/16/00 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21. Signeture of Eunarel Sarvice Licensee 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home, Inc. Stever T. Settle 6500 York Road Baltimore, Maryland 21212 23e. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth dispase Immediate Cause (Final disease or condition resulting in death) arkinsons +ears Due to (or es e consequence of) Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequença of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 25No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings aveilabla prior to completion of causa of deeth? 24a. Wes en eutopsy performed' 1 Yes 2 12 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piace of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturei Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 | Homicide

Examiner requires that the death certificete be executed P.O. Box 68760, Records, Division of Vital

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, it a Madical Examinat must be notified at

Physician

/Medical

the attending physician and thed for use es the bunel-trensit

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cate has been sig page 2 should b

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Certification:

29e. Certifier

Baltimore, Maryland 21215-0020

To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Registrar

Medical State

31. Date filed (Month, Day, Year)

29b. Signature end thia of certifian

37573

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

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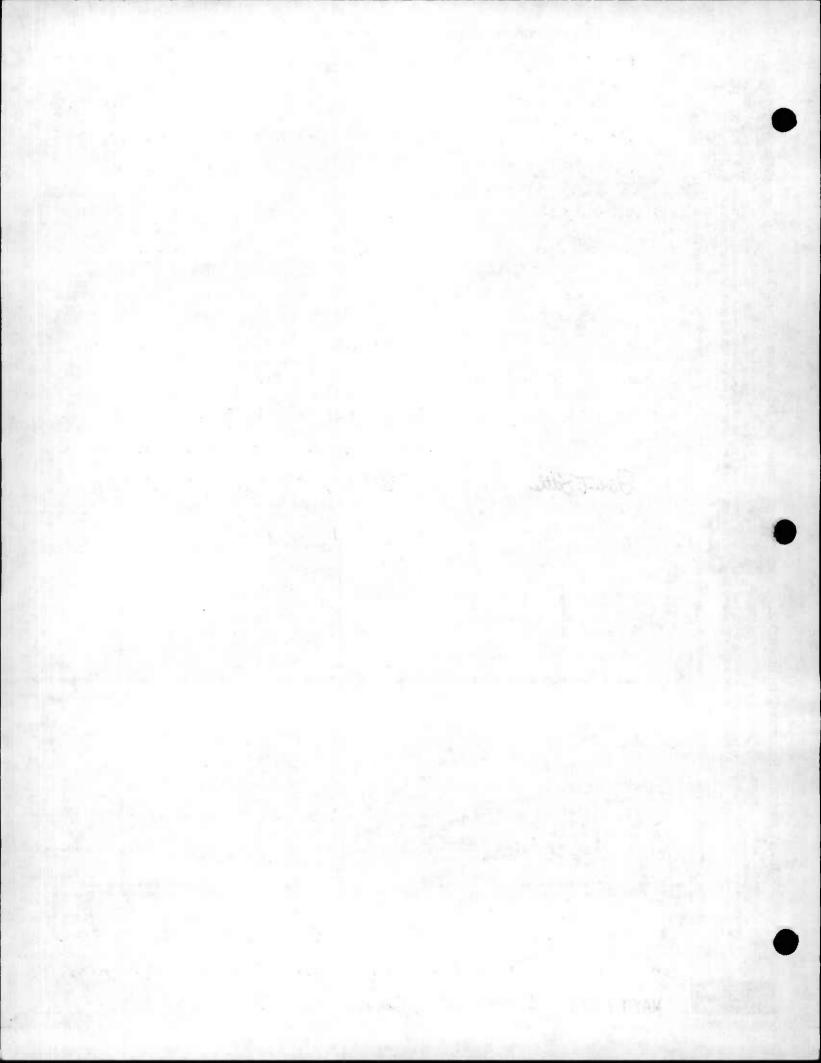
Baltimore

29d. Data signad (Month, Day, Yaar)

30. Name and address of person who a pleted cause of deeth (Item 23e) (Type, Print) 7, bell MO

Park 7770

32. Registrer's Signature



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** May 13, 2000 5:15 PM Leroy E. Harris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4s Facility Neme (If not institution, give street end number) Examiner 1117 Falls Hill Drive Baltimore | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 17, 1925 | Maryland | Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** XXM 2DF Yrs 212 20 7337 74 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle 1 Ves 2 No notifies Directo Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? tem 27 is marked other than "natural", or items 23s or other treumstic event, the Medical Examiner must be a 1117 Falls Hill Drive USA 21211 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours effect Department of Heelth end Mentel Hyglene. Important: if item 27 is merked other than "natural", or item eny injury or other treumatic even. Armed Forces:
1979s 2 No
If Yes, 3 No
If Yes, 6 No
Yeer or Detes:
1943-46 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify White à 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sheet Metal Foreman Shop Work 9 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Harry Harris Elizabeth 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Kay Kim Daughter 4 Brook Hill Court, Cockeysville, MD 21030 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method ol Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/17/00 Cockeysville, MD Dulaney Valley Mem. 22. Name and Address of Fecility Burgee-Henss-Seitz Funeral Home Inc. ef Funeral Service Lik Part1. Enter the disease shock, or heart fallure 3631 Falls Road, Baltimore, MD 21211 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line. Approximate Intervel Between Onset and Death Physician Coace Metastatic /Medical tmmediate Cause disease or condition resulting in deeth) Examiner and Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown (sease Division of Vital Records, À 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No this After this 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. tnjury et Work? Certification: 28b. Time of a or Attending P a effected. I Director: Affected in by the funer 5 Pending investigation Netural 2 Accident 1 Tyes 2 No 6 ☐ Could not be 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) in 24 hours
the Funeral Directory 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29b. Signeture and title of certilier 29d. Date signed (Month, Day, Year) 027938 60

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State

Registrar

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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

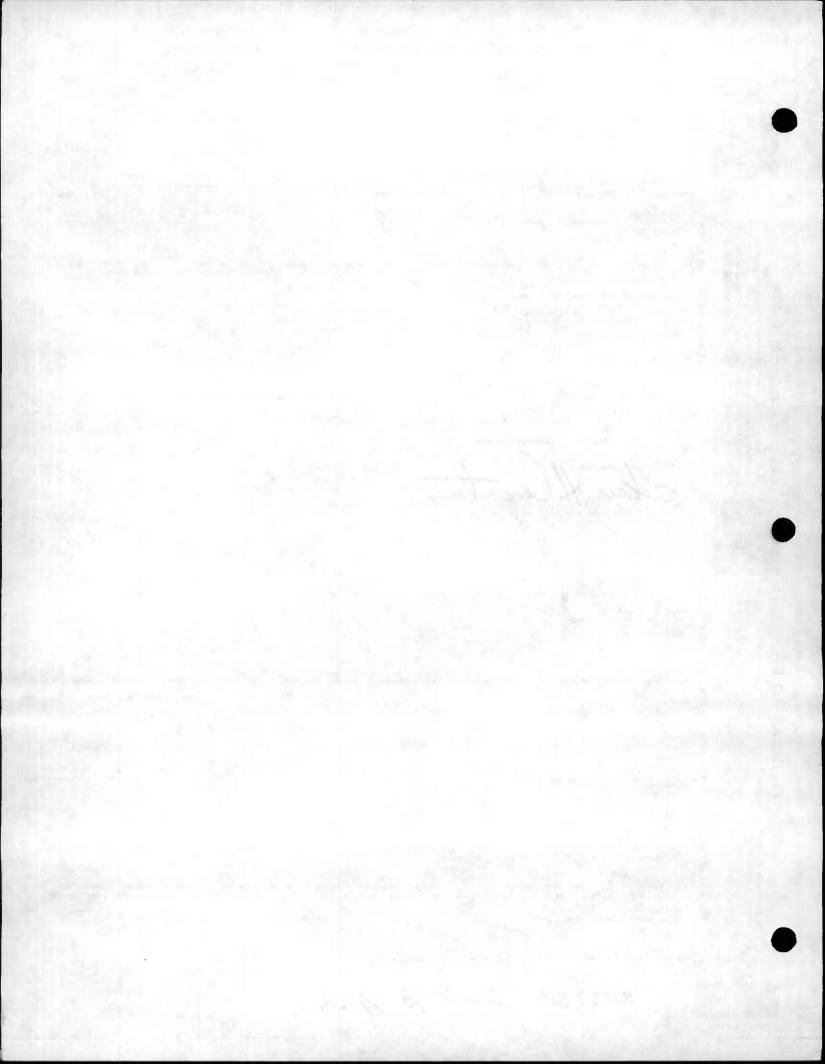
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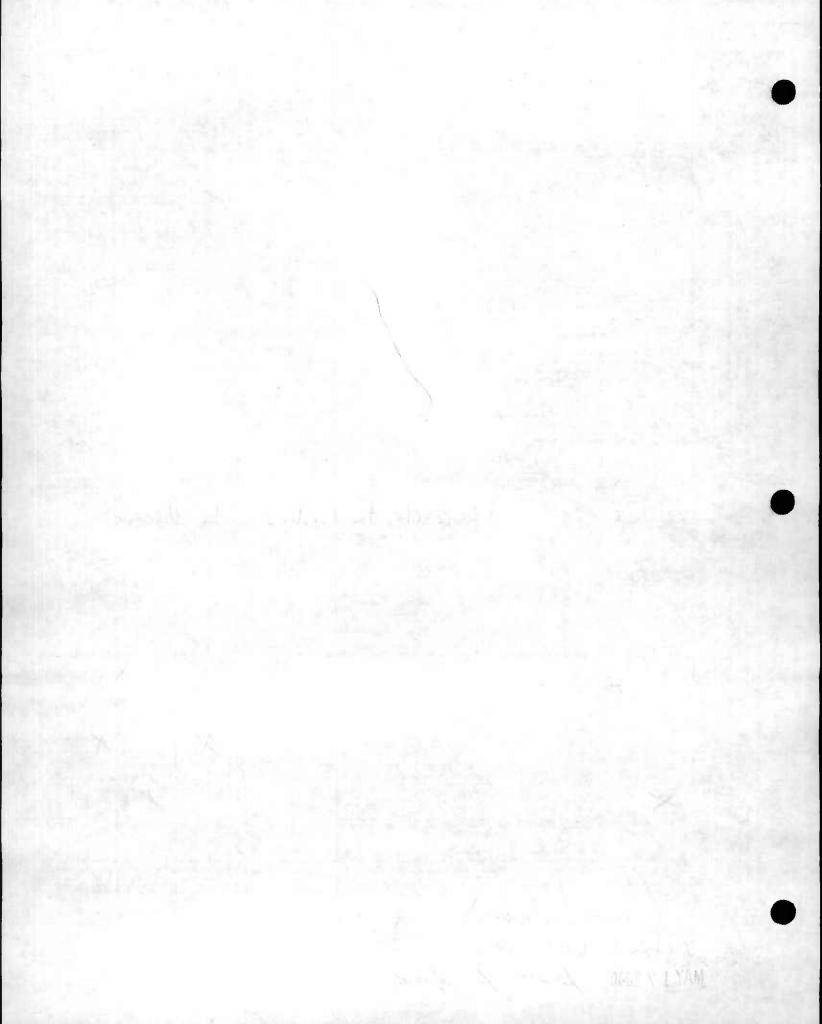
32. Registrar's Signature



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 0

ore mes		ificate of Death	Reg	. No.) / 0	
Physician	Decedent's Name (First, Middle, Last)		2. Dete of Death Month	Pay 2000	3. Time of Death	
/Medical Examiner	HERBERT D. IMES, JR. 40 Facility Name (If not institution, give street and number) 413 East Preston Street	4b. City, Town, or Lo Baltimo		12 2000 4c. County of Death N/A	12:50 P.M	
Funeral Director	217-34-2692 123 M 2C F 61 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Dete of Birth (Month, Dey, Y. 7-21-193	(ear) 9. Birthp	place (State or Foreign htry)	
Maryland H show fled at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca MD N/A BALTIMORE	tion		1	0d. Inside City Limits 1 Yes 2 No	
h with the Ma 3a or 28a-f s at be notified	10e. Street and Number 413 E. PRESTON ST.	10f. Zip Code 21202	10g. Citizen of What Country? USA			
ours after death v raft, or flems 23 Examiner mast by Funeral	1 Never Married 2 Married 1 Yes 2 XNo	as Decedent of Hispanic Origin? (Sp res, specify Cuban, Mexicen, Puerto Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.	
and within 72 ho tyglene. Ner than "naturn it, the Medical. Completed	(Specify only highest grade completed) (Give kii Elementary/Secondary (0-12) College (1-4or 5+)	nt's Usual Occupation nd of work done during most of work ONOT use retired)	ing 16	b. Kind of Business/In		
Mental Hygie urked other ti risc event, th	17. Fether's Name (First, Middle, Last) HERBERT D. IMES, SR.		e (First, Middle, Ma	SECURITY iden Sumame)	Y	
27 is marify or traumed	19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rur	orel Route Number, City or Yown, State, Zip Code) ALTIMORE, MARYLAND 21212			
Department of He Important: If Item any injury or othe ance.		18-2000 I	BALTIMORE, NERAL HOME MORE, MARY	MARYLAND P.A.		
ng physician and as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	enca of):				
that the deeth certificate be ed by the ettending physicial detached for use as the burn Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the und	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No Probably 4 Unknown				
requires the been signe should be defend by			24a. Was an a	od? ev	ere autopsy findings railable prior to mpletion of cause death?	
idelen: The law certificate has rector, page 2 Be Comp	25. Was case referred to medical	26. Place of Deal	Yes	2 No 1	Yes 2□ No	
E so D	examiner? 1 Yes 2 No Hospital: 1 Inpetient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury Natural 5 Pending (Month, Dey Year) 28b. Time of Injury	3 DOA Other: 4 Nursing Ho 28c. Injury at Work? M 1 Yes 2 No	lome 5 🎇 Residence 6 □Other (Specify) 28d. Describe how injury occurred			
To the Hospital or Attending Phy within 24 hours abter death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: T	3 ☐ Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, stree building, etc. (Specify)	ot, factory, offica	281. Location (Street and Number or Rural Route Number, City or Town, State)			
the Hospital hin 24 hours the Funeral apletely filled	29a. Certifier (Check care) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invesand manner stated.	stigation, In my opinion, death occur	red at the time, date	e and placa, and due t	o the cause(s)	
To the total to the total tota	29b. Signy Cure and title of certifier are facilities	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 13, 2000			
5		Penn Street, Balt	imore, Ma	aryland 21	201	
State Registra	AY 1 7 2000 Server 32. Registrar's Signature					



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Data of Death 3. Time of Death Year Month **Physician** 2:05 ANG SHIRLEY T. JOHNSON 05 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Days Vrs Director 216-34-2626 64 Feb.6,1936 SOUTH CAROLINA Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Yes 2□No Funeral Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23a 2700 N.CHARLES STREET 21201 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No If Yes, Give, Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: à BLACK 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th HOUSE KEEPER HOTELS 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) STEVE GREEN NORA JOHNSON 19e. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) SHERL JOHNSON-DAUGHTER HIGHSHIRE CT. DUNDALK, MD. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Buriat 2 Cremation 3 Removal from State MOUNT ZION CEMETERY 5-12-00 LANSDOWNE .MD. Ineral Service Liceny 22. Nama and Addrass of Facility LEWIS T.GWYNN FUNERAL HOME EWIS T. GWYNN 4517 PARKHEIGHTS AVE.BALTO.MD, 21215-6393 23e. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final FPSIS WEEK disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ULCER M90 NTHS UBITUS The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uas contributs to the cause of death? Records, P.O. 1 ☐ Yss 2 ☐ No 3 Probably 4 Hrknown PHENUTRITION Completed by 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medicat examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1_Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury al Work? 28d. Describe how injury occurred Division 5 Pending investigation s after dec. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 5 To the Hospital within 24 hours a Yo the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4712 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) UNION MEM-HOTP PINTHUMANA BKLTIHORE, MD 21215 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar 7 2000

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ton Jones			State of Maryland /	Department of Health and M	Mental Hygiene	1 5
AMEND ITEMS. #	23 PART T	27	28A-E DER MEO	Cortificate of Dooth	UU	10/

1. Decedent's Name of the Clint	ma (First, Middla, La ton		Jones				2. Data of D Month May	Day	Yaar	Tima of Daath 10:45 A.	
4a Facility Nama	(If not institution, gh		ber)			4b. City, Town,	or Location of Dea	th 4c. County	of Death		
	Secours Ho	ospital				Balti			N/A		
5. Social Security 218-62	23750	Sex 1 M 2 F	7. Aga (In yrs. I 45	ast birthday) Yrs.	if Undar 1 Yas Months Day		Ain. (Month, L	irth Day, Year) 03-54	9. Birthplace Country)	(Stata or Forei	
Usual Rasidenca 10a. Steta	of Decedant		10c City	, Town or Loc	ention				104	Inside City Limit	
MD	NA			altim						1 □ Yas 2 □ N X X X	
10e. Street and N			В	arcim	10f. Zip Code			10g. Citizen of	_		
1929 Hollins Street					2122			USA			
11. Marital Stetus		12. Was Dece			Was Decedant of Hispanic Origin? (Specify Yes if Yas, specify Cuban, Maxican, Puarto Rican, at		(Specify Yes or N			ndien,	
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that initiated avants											
Part II. Other sign	ificant conditions of	contributing to dea	ath but not rasu	ılting in tha un	darlying causa	givan in Part I.	23b. Di	d tobacco use co	ntribute to the	cause of dea	
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25. Was cesa refe	errad to medical			HA.		26. Placa of	Daath (Check only	ona)	/)		
axaminar?	∃ No	Hospital:	patient 2 🔯	ER/Outpatient	3□ DOA	Other	ng Homa 5□Ra		nar (Specify)		
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2 Accident 3 Suicide	data main ad	miner: On the bas	pest of my know sis of axaminat	vledga, daath ion and/or inv	occurred at tha astigation, in m	tima, data and p y opinion, daath o	lace, and dua to the occurred at tha time	a causa(s) and m a, data and placa,	and dua to the	a causa(s)	
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DHMH 16 Rev 6/95

MAY IT IND DOWN TO THE PARTY

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** Frank Krajewski 6, Mau 2000 2:00 am /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Stella Maris Baltimore Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days Hours 212-24-8581 Yrs. 80 Director 08-06-1919 MD Usual Rasidence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-(show other traumstic event, the Medical Examinar mast be notified at 1 Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1742 Ellinwood Road 21237-1716 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 72 hours efter 1 Yes 2 No WW2
If Yes, Give
Year or Dates: 1 Never Married 2/2 Merried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other than in any injury or other traumatic evant. In Manang Injury or other traumatic evant. Elemantary/Secondary (0-12) College (1-4or 5+) 8 Owner Bakery 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Jan Krajewski Adolfia Marciniak 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen S. Krajewski 1742 Ellinwood Road, Baltimore, MD 21237-1716 20b. Place of Disposition (Name of cemetary, crematory or other place)
HOLY ROSARY Cem. 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cramation 3 Removel from State 4 Donation 5 Othar (Specify) 05-09-00 Baltimore, MD 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Kaczorowski Funeral Home, P.A. 23a. Pert1. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

Approximate

Approximate Interval Batwean Onset and Death Physician Heart Failure /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Examine ig physician and as the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to for as a consequence of): Division of Vital Records, P.O. Box 68760, an/Medical Due to (or es a consequence of): esn nse Physici Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 Yes 2 No 1 Yes 2 No 25. Was case rafarred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Neturel death. 1 Yes 2 No Hospital or Attandi 24 hours after death Funeral Diractor: A 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, Stata) 4 Homicida to the Running the Fundal Diving To the Fundam Diving To the Fundam Divi XXCertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and fitte of certifier mon D43725 12/00 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Tariq Mahmood, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 16 Rsv 6/95

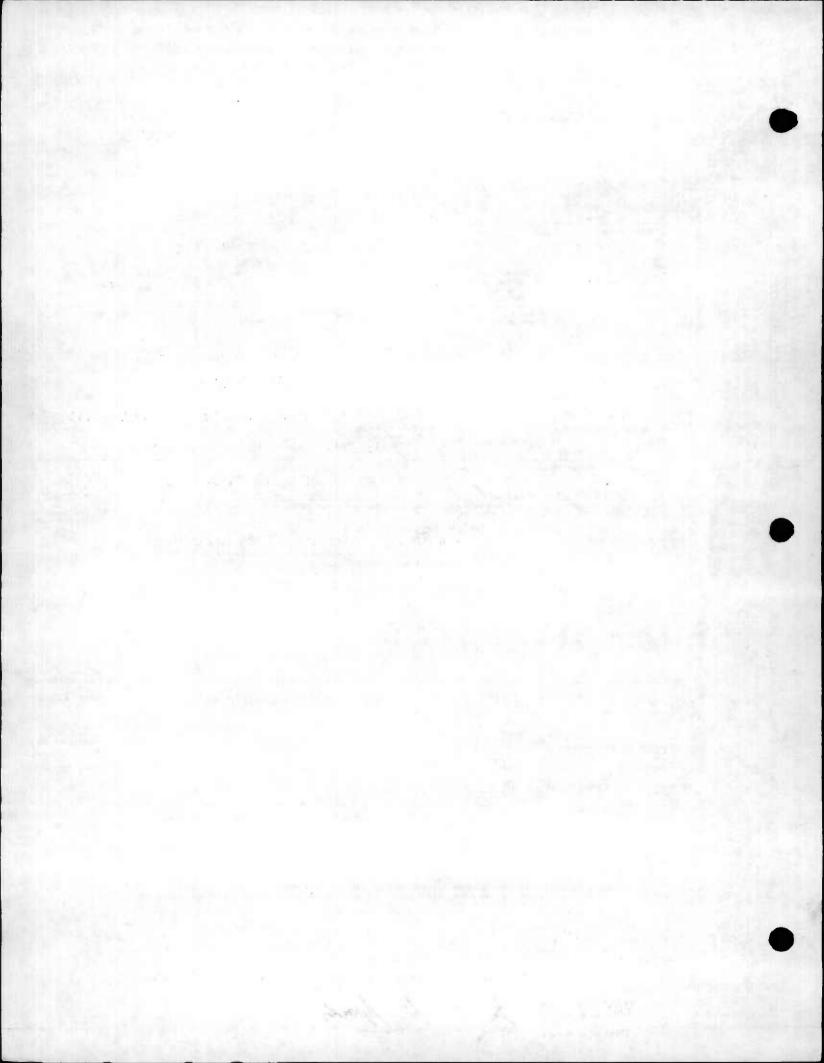
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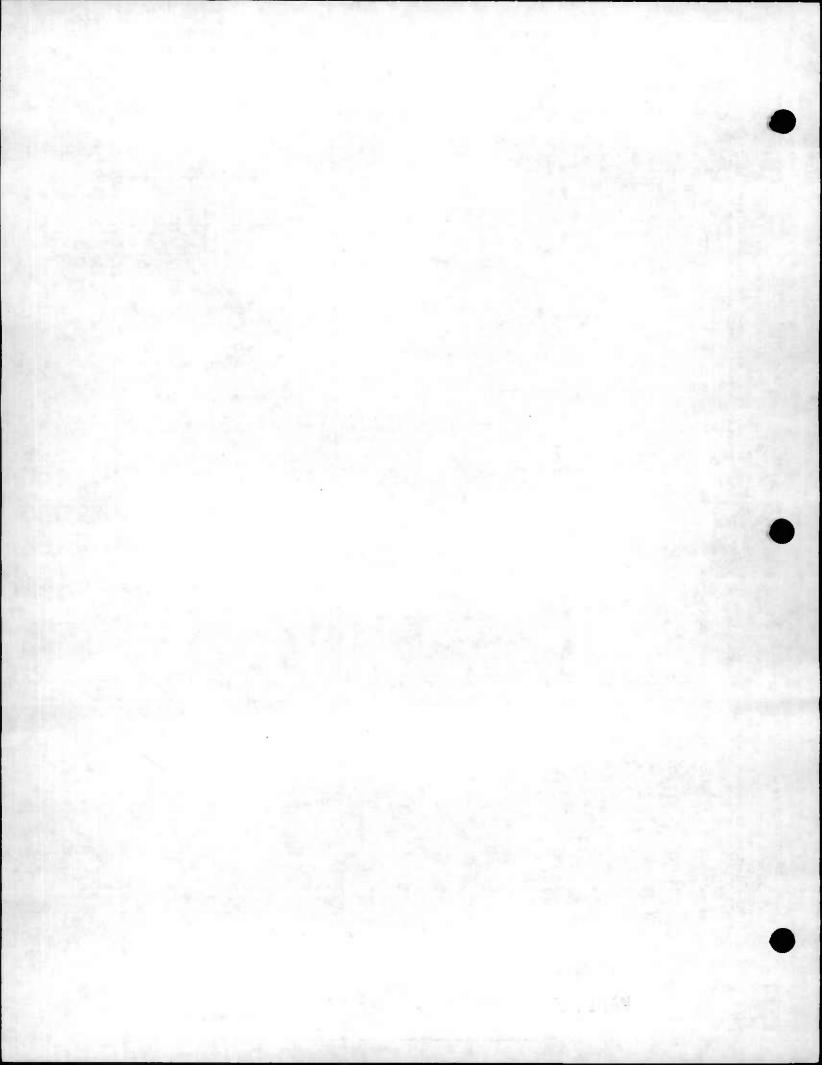


Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2000 Ilai /Medical 4b. City, Town, or Location of Chath 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner OF-MO-1188 SAMARITAN Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Oct. 18, 1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York 1 M 2□ F Director 113-26-6227 Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No **Funeral Director** Harford Maruland Bel Air 10e Street and Number 10f Zin Code 10g, Citizen of What Country? U.S.A. 1100 Broadmoor Court 21014 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Armed Forces 1 1 1 Yes 2 No If Yes, Give Year or Dates: 1953~54 filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify Specify: Be Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Church Sexton 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles W. Levey Rose Schrenk 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1100 Broadmoor Court, Bel Air, MD Elna I. Gocinski (Sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Garrison Forest VA Cem. 5/18/00 Owings Mills. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) week Examiner Examine The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Box 68760. Physician/Medical Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. FRIPHERAL VASCULAR DISTAR 1 Yes 2 No 8 robably 4 Unknown Division of Vital Records, Completed by THORACTOMY AND RESTUTE OF RIGHT PORTORNAD? 24b. Were autopsy findings available prior to completion of ceuse of death? pital or Attending Physician: The lew curs after death.

eral Director: After this certificate hes filled in by the funeral director, page 2: WPEN OBE 2 No 1 Yes 2 No 1 Yes 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner-of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medicai 29a. Certifier 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 1 A41, GOOD 8AMIARITAK HOSP 0Fmo, 5607 Day, Year) 32. Registrar's Signature 31. Date filed (Month, State MAY 1 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PM 4a Facility Name (If pot institution, give street and number) LeiseNRING 12 2000 MAY /Medical 4b. City, Town, or Location of Death 4c County of Death Examiner Baltimore Baltimore Eastpoint Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1∅M 2□F Days Yrs Director 218-10-1593 Jan. 6, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentel byglens. If he has 12 a marked of the then "naturef", or items 23a or 28a-f show other traumatic event, The Madical Exemples, mail be notified as 1 Yes 2 No Director Maryland Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 1492 Blockton Court 21114 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 (X) Yes 2 D No It Yes, Give Year or Dates! 1941-1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 3altlmore, Maryland 21215-0020 1 Yes 2 No Specify: g 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Bendix Electronics permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oths any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Griner George B. Leisenring 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3226 W. Crown Pointe Blud., Naples, Florida 34112 Sandra Diane Miskimon (Niece) 20a. Method of Disposition 20c. Location - City or Town, State 1 0 Burial 2 Cremetion 3 Removal term State
4 Donation 5 Other (Specify)
21. Signature of Funeral Service Licenses Meadowridge Memorial Park 5/16/00 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Death Physician Disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ity per ternan Records. à 24b. Were eutopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of deeth? is certificate has b 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4SNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this al or Atternate after deeth, are Director; Atter th funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Detural 1 TYes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Moepital or J
 A hours after
 Funeral Dire
 International 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier To the Hoep within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mouther notust 45757 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

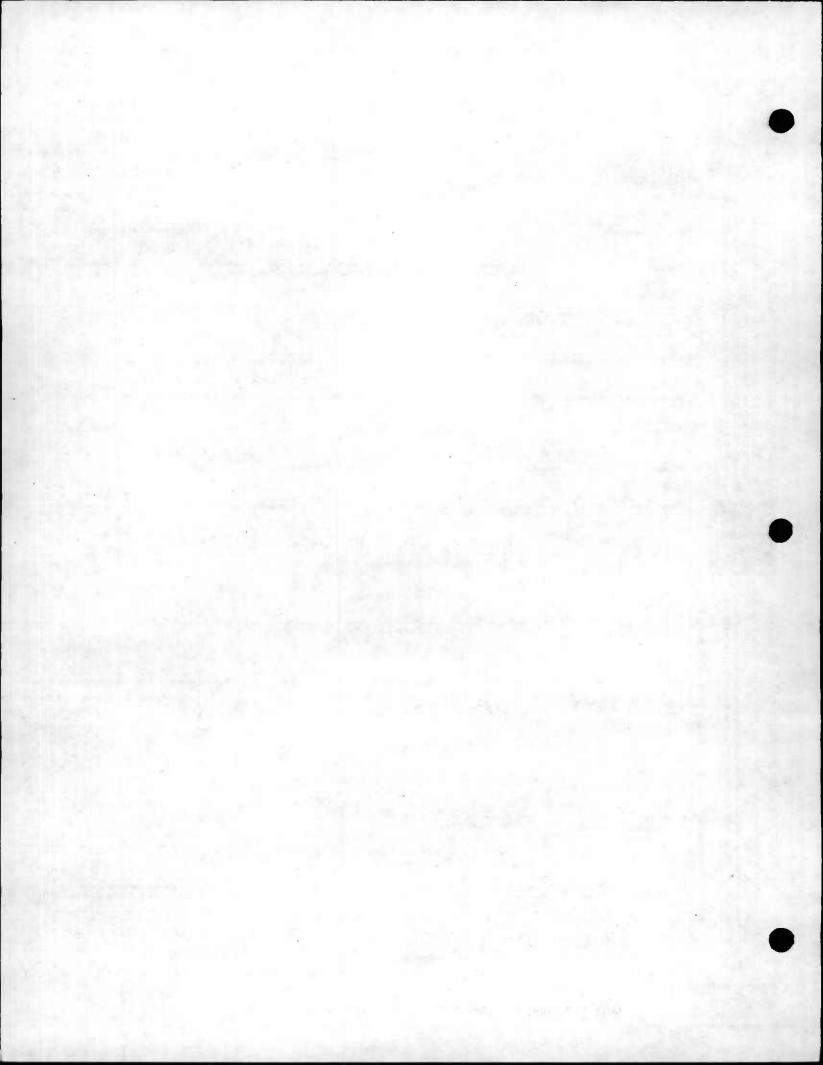
NATIVE OF CHARLES SOS (EXPLINES BAYVILLS CILLE BOXE 21274)

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 7 2000

DHMH 16 Rev 6/95

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Cegible 5.7.8.7 State of Maryland / Department of Health and Mental Hygiene

mas Lavies	Certificate of Death Reg. No.										
	Decedent's Neme (First, Middle, Last)	2. Dete of Death Month Dey Yaar	3. Tima of Death								
Physician Medical/	Thomas F. Lavicka	May 13 2000	2:45 P.M.								
Examiner		b. City, Town, or Location of Death 4c. County of Deeth									
	University of Maryland Medical Center	Baltimore N/A	A								
Funeral Director	5. Sociel Security Number 6. Sex 10/M 2 F 7. Age (In yrs. last birthday) If Under 1 Year Months Deys	Hours Min. 8. Dete of Birth (Month, Dey, Year) 9. Birth (Month, Dey, Year) 9. Birth (Month, Dey, Year) 7. P. P. P. P. P. P. P. P. P. P. P. P. P.	place (State or Foreign intry) ARYUAND								
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the Me	mp AACO. GlenBurnie										
5 6 5	10e. Street end Number 10f. Zip Code	10g. Citizan of What Cou	intry?								
th w	1007 First St 2101	60 USA	4.50								
ter death terms 23	Armed Forces? If Yes, specify Cubs	ispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) 14. Race - Amar Bleck, White									
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permit. Peges 1 end Department of Heelin Important: If Item 27 any Injury or other tr once.	21. Signejure of Funeral Service Licenses	ss of Facility Home P.A.									
80559	126 Crain Huy Sw Gken Burnie md 21061										
	23a. Part . Enter the dispase, or complications that caused the deeth. Do not enter the mode of dyir shorts or heart feiture. List any one cause on each line.	ig, such es dardiac or respiratory errest,	Approximete								
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/Medical	Immediate Cause (Fine) diseases or contilion results or in contilion e. Au Highe Privace										
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Seath ce ettendi of for use	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause give	on in Part 22h Did tohacco use contribute	23b. Did tobacco use contributs to the cause of dea								
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that that			TO THE ACTION SOL PROBERTY & ONKI								
Physician: The lew requires that the death ce this certificate has been signed by the ettendinal director, page 2 should be deteched for use; To Be Completed by Physician/			Vara autopsy findings								
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hysician; This certificate of director, pag	25. Was case referred to medical examiner? 1 1 Yes 2 1 No. Oth Hospitel: The project 2 1 EP/Outpatient 3 1 DOA Oth	26. Place of Deeth (Check only one)									
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	and menner stated.										
5 × 5 0	29b. Signature end title of certifier 29c. Licens										
14	1 the topens	.C.M.E. May 14, 200	U								
Max	30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print)										
(MX).	J- LAPON LOCKE, MD 111 Penn Stre	et, Baltimore, Maryland 212	01								
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Signatura										
Registrar	MAY 1 7 2000 Bener & South										
	1- 1-										

Physician /Medical Examiner **Funeral** Director Items 23s or 28s-f short instring notified at Director Funeral ģ Completed Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any injury or other traumatic event. Be 2000

Physician /Medical Examiner

The law requires that the death certificate be executed P.O. Box 68760. the 88 ate has been signed page 2 should be de Records, certificate of Vital After this

CHANG

Physician/Medical Examiner þ Be Completed or Attending Physician: Certification: To Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af filled in by edicai completely

Chang Rye Lee 13, 1:55 a.m. 2000 May 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Towson Baltimore Co. Stella Maris If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2XF Days 75 Yrs. 215-82-8339 March 20, 1925 Korea Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5003 Anthony Avenue 21206 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yaer or Datas: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 3 M Widowed 4 □ Divorced Korean Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coliega (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) A. Hong Lim Cuang In 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland Yong Suk Redman / Daughter 8 Leinster Garth 20b. Place of Disposition (Name of cematery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 5/18/2000 Timonium, Maryland 21. Signetura of Funeral Service Licensee 22. Neme end Address of Facility Michael E.Canapp 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23e. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death immediete Cause (Finel diseese or condition resulting in death) LUNG CANCER Due to (or es a consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or es a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one)

Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one)

29c. License number

D43725

29d. Date signed (Month, Day, Year)

6/00

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

7-

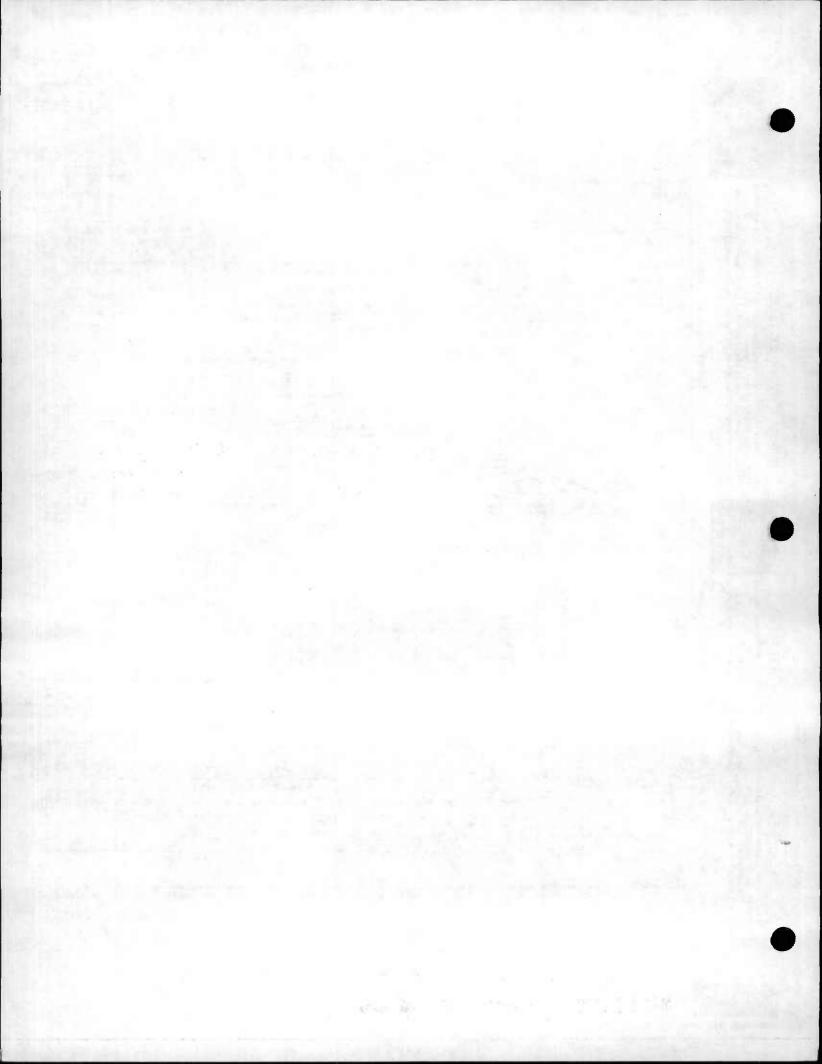
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Dete filed (Month, Dey, Year) MAY 1 7 2000

29b. Signeture and iffe of contifier

32. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** May 14, 2:30 P.M. 2000 Jane Lynn McCarron /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Rosedale Balto. Co. Franklin Woods Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) | Min. July 10, 1940 5. Social Security Number 9. Birthplace (State or Foreign County) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2P(F 59 Yrs. Director 220-36-1417 Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show with fujury or other traumatic event, the Medical Exam for must be notified and plate. 1 X Yas 2 □ No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1209 Battery Avenue 21230 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Bleck, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 5 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Arch Diocese of Balto. 12 Teacher 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Ida M. Rudolph William J. McCarron 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Joyce A. McCarron 103 Water Fountain Way Unit 201, Glen Burnie, Mc 20a. Method of Disposition

1 Burial 2 Cramation 3 Removel from Stata 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 5-17-00 Brooklyn Park, MD. 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 21. Signature of Fune/al Service Liner 22. Nama and Address of Facility McCully-Polyniak Funeral Home P.A. un 3204 Mountain Rd. Pasadena, MD. 21122 23a Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause or each line. Approximata Intervel Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical 5 Days Backeremia Examiner Dua to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The lew requires that the deeth certificets be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Diseese or Injury Due to (or ss e consequence of): Box 68760. Physician/Medical that initiated events rasulting in death) Last Dua to (or ss a consequence of) use as P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cardiomyopaby signed b Records, þ 24b. Wara autopsy findings eveilable prior to complation of causa of death? Completed 24a. Was an sutopsy page 2 s 1 Yas 2 No 1 Yas 2 UN certificate Division of Vital or Attending Physicien: aftar death. Director: After this certifica Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 27. Manger of Desth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury st Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homleide To the Hospital of within 24 hours at To the Funerel D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical

State Registrar

31. Date filed (Month, Day, Year) MAY 1 7 2000

29b. Signatura and titla of certifier

7845 concusced Red suite 100, Glenburnie, MD 21061 · Raguraj. mp 32. Registrar's Signatura

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

MD

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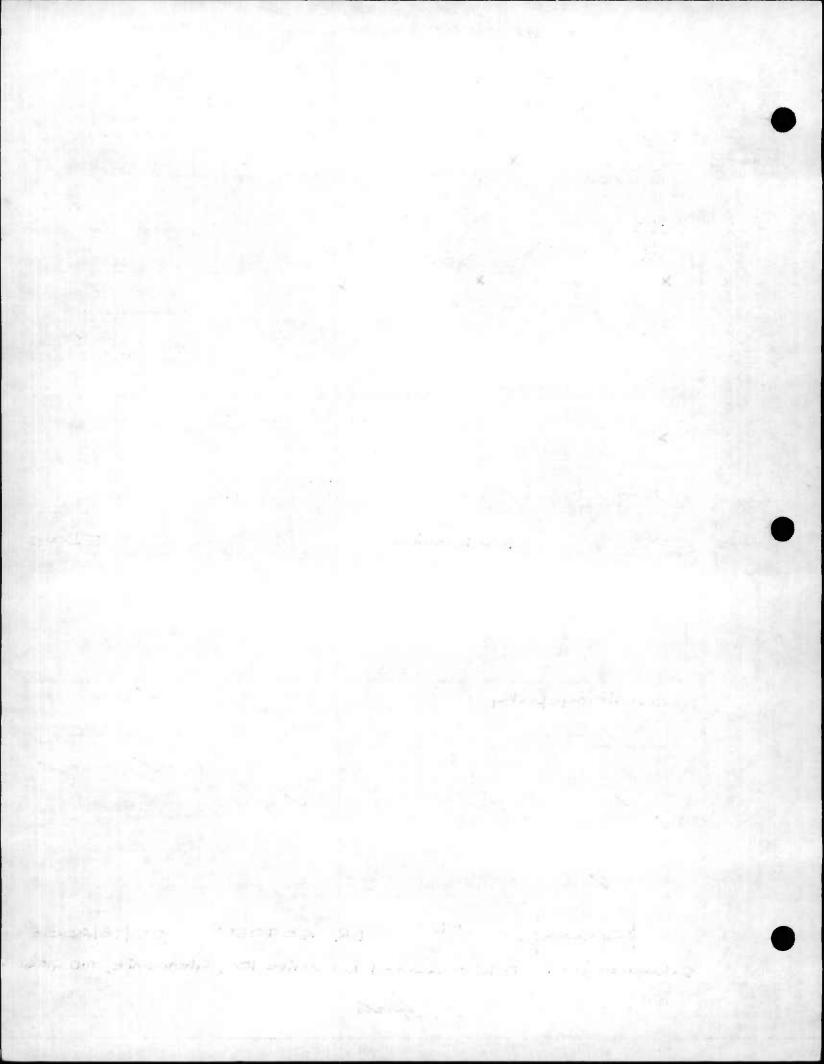
29c. License number

BR

6070508

29d. Data signed (Month, Day, Year)

05 16 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Yee 1145 Am Sherri Kay 2000 Mitchell May 15 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth 426 Riverside Drive Pasadena Anne Arundel If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) Oct. 12, 1946 Birthplece (State or Foreign Country) 5. Sociel Sacurity Number 7. Age (In yrs. lest birthday) Months Days Hours 1 M 2 F 53 Yrs. 417-64-4442 Alabama Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 621 South Luzerne Avenue 21224 USA 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates; Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bieck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Licensed Practical Nurse Medical 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Gilmer Lotus Farrie Ray 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John Mitchell - Spouse 621 South Luzerne Avenue, Baltimore, MD 21224 20b. Plece of Disposition (Neme of cematary, crametory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. May 16 Baltimore, MD 21. Signeture of Funeral Service Licental 22. Neme end Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Pert . Enter the disease/or complications that cause of deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each limit of the complications are cause on each limit of the complex of Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting In deeth) 2 months ECUPPENT CANCER CELL CHACIWAY houth Due to (or as a consequence of): MAZNUTHITZO ININITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or es e consequence of) Squ AMOUS (RLL CANCIUSMA RTONSIL and Nech Due to (or as e consequença of): RNECK SGUAMOUXBLE CANCISONA Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown TRACHER ESOPHADRIN PISTVIA 24b. Were eutopsy tindings available prior to 24a. Wes an autopsy Hypo PANATHYNOTOISM completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) daughter Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA residence 28d. Describe how injury occurred

Physician /Medical Examiner ettending physician and I for use as the burial-transit that the death certificate be execu

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Physician

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Baltimore, Maryland 21215-0020

filed within

Examiner Physician/Medical à Completed Be Certification: To

25. Wes case referred to medical 1 Yes 2 No

28b. Time of

28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 5 Pending investigation 1 Naturel 2 Accident 6 Could not be 3 Suicide 4 Homicide

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the ceuse(s) end manner as stated. 29b. Signature and title of certifie

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner steted. 29c. License number 29d. Dete signed (Month, Dey, Year)

656GNCHARLES ST GATMONE NO 20204

n 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

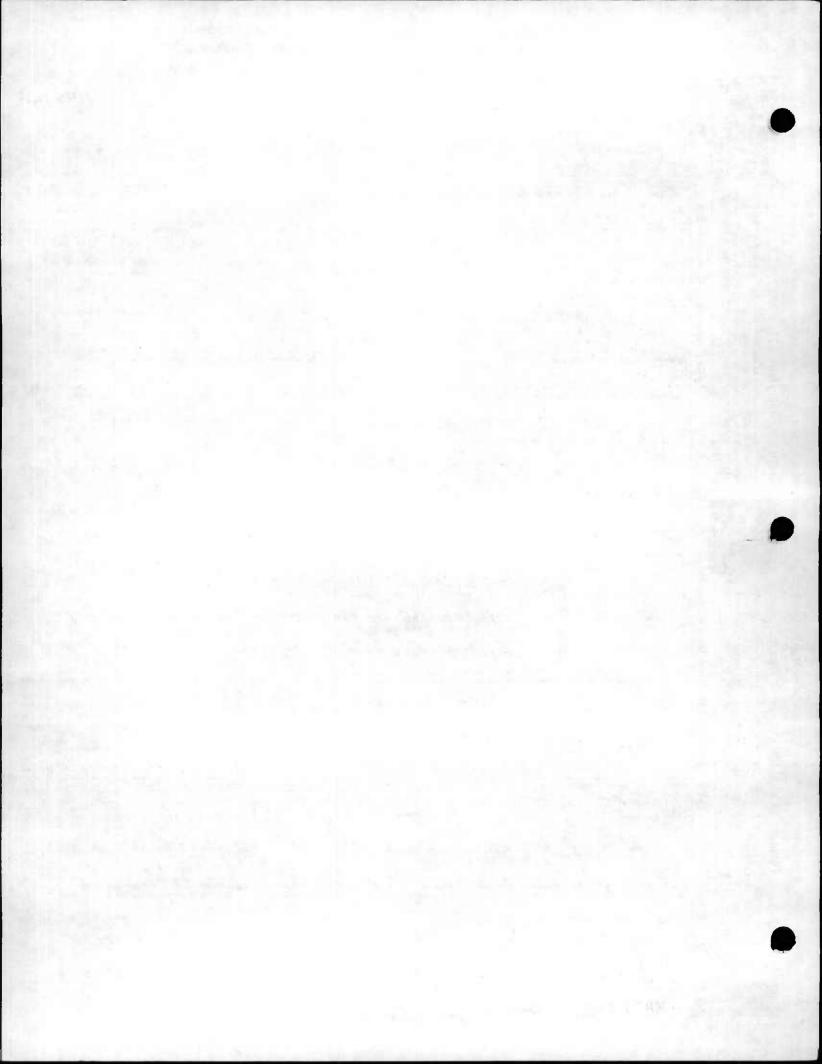
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RSAUNDERS 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

MAY 1 7 2000

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev **Physician** MAY Varella H. McDonald Fourteenth 2000 7:15 PM /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore AVE 900 cator SAH If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□M 2♥F Yes Director 214-18-6542 90 Oct 20, 1909 Maryland Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or itema 23a or 28a-f ebow other traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 HNo Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 715 Maiden Choice Lane CR 317 21228 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or iter eny injury or other traumatic event, the Medical Examinat 2006. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2∑ No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker/teacher Own Home/School 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Dr. Harry Clyde Hess Varella Knight Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19e. Informant's Name/Relationship (Type, Print) 715 Maiden Choice Lane CR 317, Catonsville, MD J. Robertson McDonald / husband 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 5/17/2000 Timonium, Maryland 4□Donetion 5 ☐Other (Specify) entombment Dulaney Valley Mem. Gardens 22. Name end Address of Fecility Hubbard Funeral Home, Inc. se, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, List only one cause on each line. 4107 Wilkens Avenue, Baltimore, Maryland 21229 anuto Approximete Intervel Between Onset end Deeth 23a. Pert Enter the disease shock or heart failure. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physicien for use es the buria Division of Vital Records, P.O. Box 68760 edicai Due to (or as a consequence of): Physician/M 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. McVorald Varella signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown b 24b. Were eutopsy findings aveilable prior to completion of cause of death? should 24a. Wes en eutopsy performed? Completed peen s Pes page 2 25 No certificate 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investination in my opinion death account at the cause(s) and menner as stated. edicai 29a. Certifier (Check only one) Iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) cause of death (Item 23a) (Type, Print) 30. Name and address of pi Baltinore MD

ORIGINAL

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32. Redistrer's Signature

31. Date filed (Month, Day, Year)

MAY 1 7 2000

State

Registrar

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			1. Decedent's Nama (First, Middle, Last) Certificate of Death 2. Data of Death 3. Tima of Death														
	Physiciar /Medica Examine		1. Decedent's Nama (First, Middla, Last) George L. Mann, Jr.									Month	Day Day	2 do o	3. Tima of Death 1308		
			4a Facility Nama (If not institution, give street and number) St. Agnes Health Care								4b. City, Town, or Localion of Death Baltimore Ac. County of Death n/a						
	Funeral Director		5. Social Security N 470-28-2	umber	6. Sex				birthday) If Under 1 Yes. Months De		Hours Min. (Month, D		Day, Year) Co		laca (Stata or Foraign try)		
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	28a		10e. Street and Number 10f. Zip Code									-		What Coun	try?		
	should be filed within 72 hours after death with the Maryland and Mental Hygiane. The Hygiane. Transfed other than "natural", or items 23a or 28a-f show marke event, the Medical Examinar must be notified a		3300 Benson Avenue Apt. 233							21227 U.							
			11. Marital Status 1 □ Navar Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Evar in U Armed Forces? 1 ☑ Yas 2 □ No If Yas, Giva Yaar or Datas:					S. 13. Was Decedent of Hispanic Origin? (Specify Yas, specify Cuban, Mexican, Puerto F				ecify Yas or N Rican, atc.)	Yas or No- an, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. Specify: White				
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21215-0020	filed within 72 hours after Hygiene. ther than "natural", or lite ent, the Medical Exercise		(Specify only highast grada complated) Elamanlary/Secondary (0-12) Collega (1-4or 5+) 8				5+)	(Giva kind of work done during most of working life. DO NOT use retired) Roofer/Sheet Metal Work									
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lar	Aentel Aentel Aced o		George L.	Mann,	Sr.						Pyrle Reed						
, Maryland	d2 her		19a. Informant's Name/Ralationship (Type, Print) Rose M. Mann / wife 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3300 Benson Ave. Apt 233, Baltimore, Maryland 21227														
Baltimore,	permit. Pages 1 en Depertment of Heelt Important: If Item 2: eny injury or other page.		20a. Mathod of Disposition 1 \(\text{XBurial 2 Cramation 3 Ramoval from Stata}\) Description 1 \(\text{XBurial 2 Cramation 3 Ramoval from Stata}\) Washington National Cem. 5/18/2000 Suitland, Maryland 22. Nama and Address of Facility Hubbard Funeral Home, Inc.														
4	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Corowary Atheroscolerosis with 95%								Approximata Intarval Batween						
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Division of Vital Records, P.O.	The lew requires that the deeth certificate be ste has been signed by the attending physicis page 2 should be detached for use as the bu		Chronic OBSTrucTive Palmonary Disease								s an autopsy formed?	co	ara autopsy lindings ailabla prior to mpletion of cause daath?				
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			29a. Certifiar (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.														
30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)							29d. Data sign	9d. Data signed (Month, Day, Year)									
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Data of Death 3. Tima of Death **Physician** Month Bessie 4:10 a.m Mason May 8, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1210 N. Bentalou Street Baltimore n/a If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 200F 217-18-0069 78 Yrs Director May 5, 1922 Va. Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore XXYas 2 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 1210 N. Bentalou Street Funeral than "natural", or hams: the Medical Examinar my 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - Amarican Indian 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married 1 Yaa 35 No If Yas, Give Year or Datas: Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 St Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Dept. of The Army Elementary/Secondary (0-12) College (1-4or 5+) 4 Ft. Meade, Md. Personnel Specialist 18. Mothar's Nama (First, Middle, Maiden Surname)
Bessie Smith 17. Father's Nama (First, Middle, Last) and 2 should be Joseph Hatchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health a Important: if Item 27 is any Injury or other RDGs. Joeanne M. Taylor Daughter 1153 N. Bentalou Street Baltimore, Md. 21216 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Durial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial Park May 12 Baltimore, Md. 22. Name and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Los 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Entar the disease, or complications that caused the disease, or heart failure. List only one cause on each interest of the complete of the cause of t Do not enter the mode of dying, such as cardiac or raspiratory arrast, Approximata Interval Between Onsat and Death Physician /Medical Immediate Cause (Final diseasa or condition rasulting in death) PANCREAS METASTATIC LYEAR Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac Records. þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Attending Physician: 25. Was casa refarred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Masidence 6 Othar (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Watural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident or Attend after deatl Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide e Hospital o 124 hours al e Funeral D letaly filled i 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end place, and dua to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) Within 2 To the it 29b. Signetura and title of certifie 29d. Data signed (Month, Day, Year) 10100 ted cause of death (Item 23a) (Type, Print) 31. Pata filed (Month, Day, Year) Registrar's Signature State MAY 1 7 2000 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 16 Day Month Physician 2000 May Guy David Moser 12:30 pm. /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care at Cherrywood Baltimore Reisterstown 5. Social Security Number 7. Aga (In yrs. last birthday)
75 Yrs. If Undar 1 Yaar If Undar 24 Hrs. 6. Sex 1 M 2 F Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year)
Feb. 8, 19 **Funeral** Days 212-22-6293 1925 Director Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hygiena. Important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinations are notified as Owings Mills Md. Baltimore 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 214 Uppergate Court 21117 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaer or Detes: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Baltimore County Highway Superintendent 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) 8 Guy E. Moser Florence E. Merryman 2 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Straet and Number or Rural Routa Numbar, City or Town, Steta, Zip Coda) Mary E. Moser Wife 214 Uppergate Court, Owings Mills, Md. 21117 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Dala 1 Surial 2 Cramation 3 Removal from Stata Evergreen Mem. Gardens May 19,2000 Finksburg, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22, Name and Address of Facility
Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills. Md. 21117 23e. Part 1. Entar ha diseese, or complications that ceused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximala Intarval Batween Onsat and Daath **Physician** /Medical Immediate Ceuse (Final disaasa or condition rasulting in death) Examiner Due to (or as a consequence of) the death certificate be asscuted physician and is the burial-trans Sequantially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): use as attanding ŏ Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably ♥ Unknown þ should t 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? Completed Mel. page 2 s certificata hes 1 Yas 2 No 1 ☐ Yas 2 No Physician: 25. Was cesa refarred to medicel axaminar? Be 26. Place of Deeth (Check only one) Hospital: Othar: 4 Vursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yes 2 No s efter deeth.

I Director: After this could be to by the funerel director. edical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Dete of injury (Month, Dey Year) To the Hospital or Attending Pt within 24 hours efter deeth.
To the Funeral Director: After th completely filled in by the funerel 27. Mennar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Netural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be detarmined 28f. Locetion (Street and Number or Rural Routa Numbar, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homloida Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and place, and dua to the causa(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the ceusa(s) and manner stated. 29a. Cartifier

State Registrar

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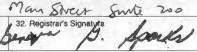
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30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signatura and titla of certifiar

31. Date filed (Month, Dey, Year)



29c. Licansa number

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29d. Data signad (Month, Dav. Year)

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29a. Cartifian

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

Theodore King M.D.

MAY 1 7 2000

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32. Registrar's Signature

30. Name and address of person who combining cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

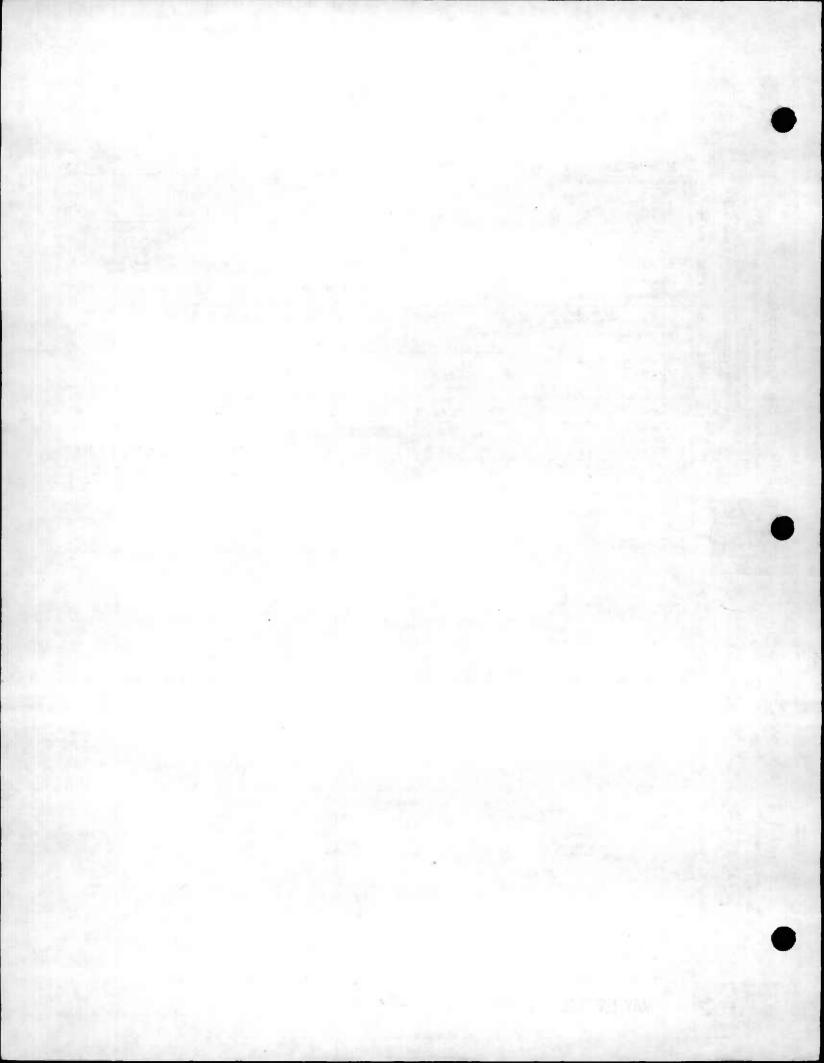
29c. License number

111 Penn Street, Baltimore, Maryland 21201

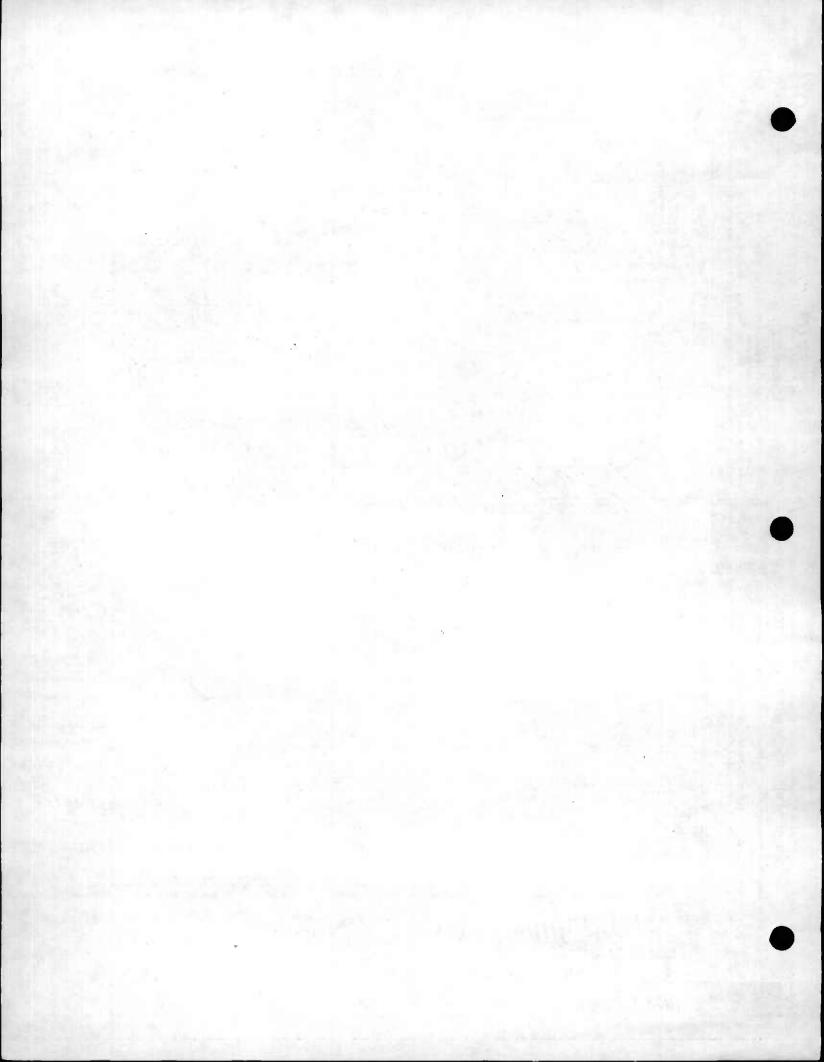
O.C.M.E.

29d. Date signed (Month, Day, Year)

May 15, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 0:10 **Physician** /Medical et and number) 4b. City, Town, or Location of Death Examiner owson If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 10 M 20 F Marylana Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If them 27 is marked other than "natural", or florms 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified. 10c City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director ITIMOR 10g. Citizen of What Country? 10f. Zip Code . Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 V Married 1□Yes 2□No Maryland 21215-0020 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ing most of working (Secondary (0-12) College (1-4or 5+) truction 17. Father's Name (First, Middle, Last) Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cemetery, cremetory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Fugural Service License issease, or complications that caused the death. Do not enter tailure. List only one cause on each line. 23a. Partt. Enter th the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) min Examiner Due to (or as a cons Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-tray The law requires that the death certificate be ex P.O. Box 68760. nus Cuncer Due to (or as a consequence of) 23b. Did topacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2□No 3 Probably 4 Unknown Records, ğ Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to this cartificate has been completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) Wy El 1 Yes TONO Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signa 29d. Date signed, (Month, Dey, Year) 2 who completed cause of death (Item 23a) (Type, Print) BMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 7 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DOROTHY MILNER MAY 12:58 PM 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE If Under 24 Hrs. Birthplace (State or Foreign Founds) If Under 1 Year 5. Social Security Number 7. Age (In yrs. jast birthday) **Funeral** Days 1 M 2 F Months Yrs. Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits or 28a-f show timone 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 1 Yes 2 No Specify: Specify: BL þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use setired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flaid within 7 Department of Health and Mental Hyglene. Important: if Idem 27 is marked other than "n any Injury or other traumetic event, the Med dotte. Elementary/Secondary (0-12) College (1-4or 5+) Maker Home . Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 2 199. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num nber, Çity or Town, State, Zip Code) 22 21225 Galto 110, MD, 2/26 20c. Location - City or Town, State 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 □ Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) nsdowne ON Cemeter 22. Name and Address of Fecility P. march Fredhilfon Balto. 23a Park File disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final SEPSIS WEEKS disease or condition resulting in death) Examiner Due to (or as a consequence of): STAGE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of). and physician a DIABETES MELLITUS Physician/Medicai Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION à 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed CORONARY ARTERY DISEASE 1 ☐ Yes 2LINO 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death edical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 QNatural 5 Pending investigation • Euneral Director: After bletchy filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Vithin 2 29c. License number

that the death certificate be executed Box 68760. P.O. Records, Division of Vital or Attending Hospital

hours after

Maryland 21215-0020

altimore,

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year) MAY 1 7 2000

HARBOR

HOSPITAL CENTER 32. Registrer's Signeture

MD

ORIGINAL

29d. Date signed (Month, Day, Year)

AS2441614- A10 MAY, 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIV KUMAR PATIL 3001 SOUTH HANDVERSTREET BALTIMORE MD21230

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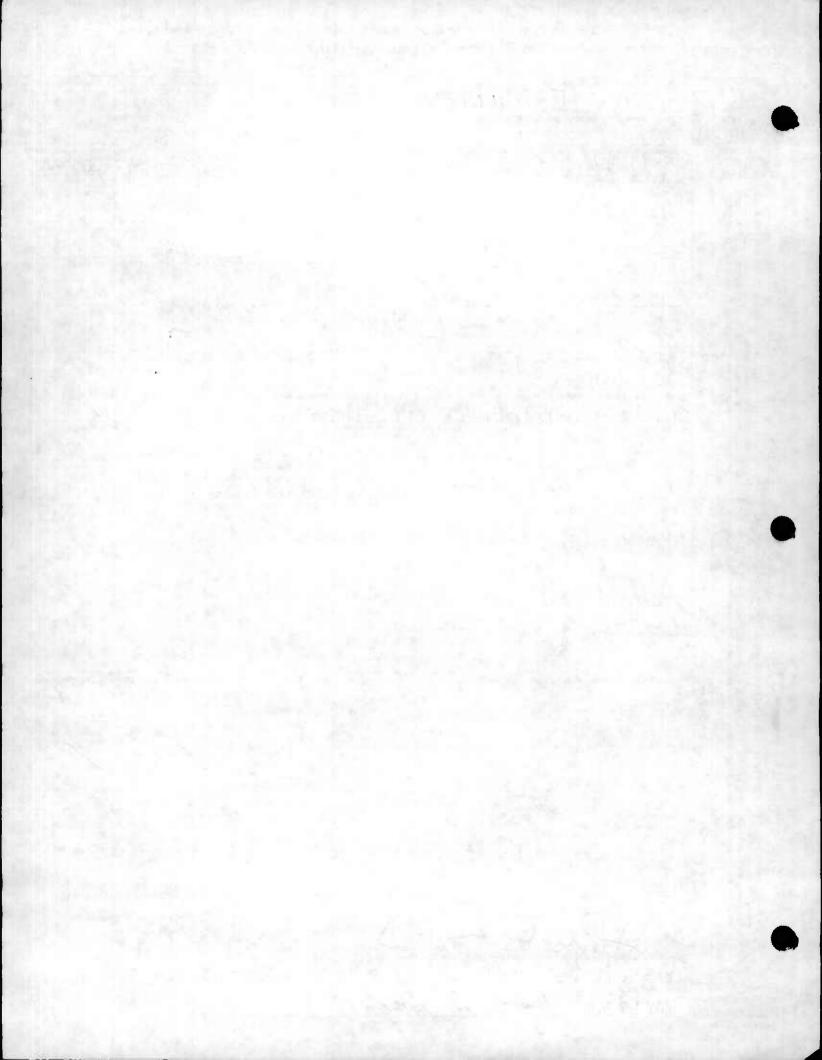
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(Mogth, Dey, Year)

31. Dete file

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32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Date of Death 3 Time of Deeth Regina W. Niederhauser May 14, 2000 4:50 AH 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Anne Arundel Genesis Eldercare at Hammonds Lane Social Security Number 6. Sax 7. Age (In yrs. last birthda If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Data of Birth (Month, Day, Year) April 14, 1915 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1□ M 2□X Months 85 Yrs. 218-03-3649 Usual Rasidance of Decede Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida Cltv Limits 1 Yas 2 No Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizan of Whet Country? 209 Waterfountain Court 21060 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) Elemantary/Secondery (0-12) Collega (1-4or 5+) Homemaker 8th Ω 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Emily Charles Edward Nagle Sparks 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 8320 Dock Road Pasadena, Maryland 21122 Charlette Pohler (Daughter) 20b. Place of Disposition (Neme of camatary, cramatory or other place) 20a, Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Glen Haven Memorial Pk. 5/16/00 Glen Burnie, Maryland 21. Signature of Duaral Service Lin 22. Name and Addrass of Facility McCully-Polyniak Funeral Home, P.A. 23a. Pert1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Approximate Approximate Interval Batween Onsat and Daath immediate Causa (Final disaase or condition rasulting in deeth) ARTERIO SCLERUTIC CARVIOVASCULAR Due to (or es e consequance of) Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DBMEN 71/A 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yas 2 No 1 Yes 2DINO 25. Was casa referred to medical axaminar? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Physician/Medical Examiner

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Certification: To

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The law requires that the death certificate be executed

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Department of Important: If it any injury or o

and 2 should be filed within 72 hours after eaith and Mental Hygiens.

3altimore, Maryland 21215-0020

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated events rasulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

1 Yas 2₽No 27. Mannar of Death 1 DNatural 5 Panding invastigation 2 Accident

28a. Data of Injury (Month, Day Year) 6 Could not be

28b. Tima of 28c. injury at Work? 1 Yes 2 No

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29a, Certifier

3 Suicida

4 Homicide

To the best of my knowledge, deeth occurred at the time, data end plece, end due to the causa(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and plece, and due to the causa(s) and mannar stated.

29b. Signature and title of certifie

29c. Licensa number 021776 29d. Date signed (Month, Day, Year) 2000

BACTIMORE MOZGE

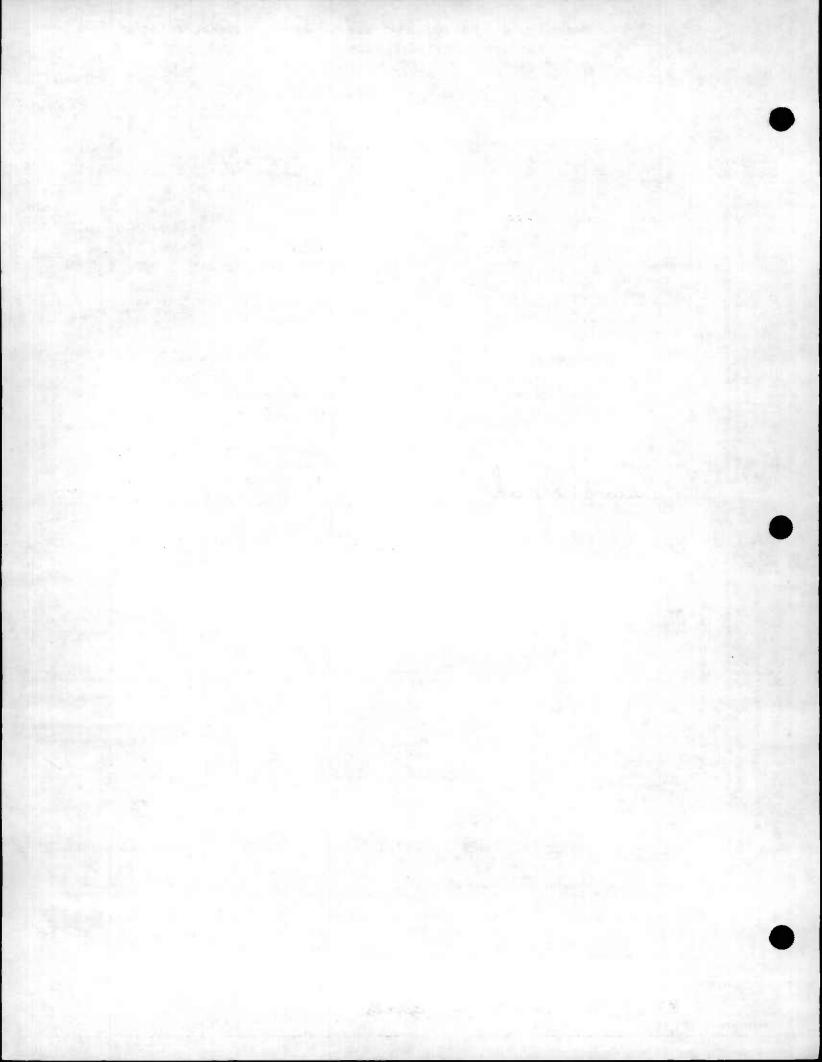
30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print) SURYA P. MUNDRA MD 3001 S-HAMOVER ST,

31. Date filed (Month, Day, Year)

32. Registrar's Signatura

28a. Place of Injury - At homa, farm, streat, factory, office bullding, atc. (Specify)

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Year Joseph Richard Norris TA 2000 0650 am 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MORC 79 n/a If Under 1 Year 8. Data of Birth (Month, Day, Ye Nov. 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1□ M 2∑ Days Yrs 1926 Maryland 73 212-22-4174 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2√ No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Holland Hill Court 21228 United States 12. Was Decedent Ever in U,S. Armed Forces? Wss Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - Amarican Indisn, Bleck, White, etc. 11. Marital Status 1 □Yas 2 □ No If Yes, Giva Year or Dates: 1 Nevar Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 chauffeur department store 17. Fsthar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Mae Dorn Jesse Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21228 Vivian C. Norris - wife 15 Holland Hill Court, Baltimore, Maryland 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/15/00 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue 21229 Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Betwaen Onsat and Death NEUMONIA Immediata Cause (Final disaasa or condition rasulting in deeth) ONE MONTH Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Wara autopsy findings available prior to completion of causa of deeth? 24a. Was an eutopsy performed? 1 ☐ Yas 2 No 1 Yas 2 No 25. Was casa refarred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other (Specify) 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 TYas 2 TNo 2 Accident 6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rurel Routa Number, City or Town, Stata) 4 ☐ Homicide

Box 68760 Vital to Division 8

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Registrar

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumstic event, the Medical Examiner must be notified an Date.

Physician

/Medical

Examiner

Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

certificate

after deat Director:

Baltimore, Maryland 21215-0020

death with the Maryland

29c. License number P19600

DY. NASSERI

Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, end due to the ceuse(s) and manner es stated.

On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end manner stated. 29d. Date signed (Month, Day, Year) may, 11, 2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

CATON AVE 31. Data filed (Month, Day, Year) 32. Registrar's Signatura MAY 1 7 2000

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Certifica	te of Death	1	Reg. No.	0001		
	_	1. Decedent's Nama (First, Middla, Las	at) .			2. Data of Dea Month	th Day Yaa	3. Time of Death		
Physicia /Medica	_	Denise Y. (Ineal			05	15 00	6:42 pm		
Examine		4a Facility Nama (If not institution, give University o	e street and number)	nd	0 111	r Location of Death	Balty	nore City		
Funeral Director 2.5 Social Security Number (6. Sex 7. Age (In yrs. last birthday) Hi Under 1 Year If Under 24 Hrs. 8. Dala of Birth (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day) Hours Min. (Month, Day, Yrs. 4 Hours Min. (Month, Day) Hours Min. (Month)								irthplece (State or Forman Country)		
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3a or 28	I Director	10e. Street and Number	1 Street	10f. Z	ip Coda 2 (202		10g. Citizan of Whet C	Country?		
5-0020 72 hours after death with the Maryland natural", or items 23s or 28s-f show deal Examples must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Married	12. Was Decedent Evar in U,S Armed Forcas? 1 Yas 2 No If Yas, Giva		edent of Hispanic Origin? (ecify Cuban, Maxican, Pua	Specify Yas or No- irto Rican, atc.)	14. Race - An Black, Wh Specify:	narican Indian, iita, atc.		
72 hours	0	3 Widowed 4 Divorced	Yaar or Datas:		10		10 10 10			
市場を記載し	Completed	15. Decedent's Ed (Specify only highest gra	College (1-4or 5+)		ual Occupation ork dona during most of w usa retired) ction Cen	orking	Activite	of therapies		
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Baltimoperant: Peg Department important: Peg Partment		21. Signature of Funaral Sarvice Licen	Chon a loi	22. Nama (and Addrass of Facility	Betts	Funeral Backs M	Home (d. 21213		
	-	23a. Part1 Enter tha disaase or compshook, or heart tailura. List only	plications that caused the death.	Do not antar tha mo	oda of dying, such as cardi			Approximata		
Physician		shook, or heart tailura. List only	ona causa on each lina.					tnterval Batween Onsat and Daath		
/Medical		Immedieta Ceusa (Final	0:	rahos	ci'c					
Examiner		diseasa or condition rasulting in daath)	a.	as a consequance of				1		
THE PERSON NAMED IN	ě		Dua to (or	as a consequance of	<i>i</i> ,					
n and el-transit	Examine	Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or injury	b. Dua to (or	as a consequance of):					
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Hospi 24 hour Funer stely fill	edical C		ysician: To the best of my know niner: On the basis of examinatio and manner stated.							
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PIRS - DI 3274							05/15/00			
m	-	30. Name and address Syperson who	completed cause of death (Item)	23a) (Tyne Print)	11001	(00/10/			
V		University o	of Marylan	nd a	22 Sout	h Gr	eene	54.		
State Registra	ç	31. Data filed (Month, Day, Year) MAY 1 7 2000	32. Registrar's Signetu	la fra						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 3:00 AM PARTHEAN 05-08-PEARSON 200C 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA BALTIMORE 2638 EDMONDSON AVENUE If Under 1 Yaar | If Under 24 Hrs. 9. Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Months Days 10 M 20 F 216.24.807 30 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yas 2 No M BALTIMORF 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code EDMONDSON USA 2638 AVENUE 12. Was Dacedant Evar in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, etc. 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Marriad 2 ☐ Married 1 Yas 2 No Specify: BLACK Specify: 3 Ø Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) ABURER NIA NOUSTRY MACKING 10TH GRADE 18. Mothar's Neme (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) LURTON MILLINGS STEWART 19a. Informant'a Name/Ralationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) BAU CLAYMOUNT AVE. BALTO 'ARMOLETHA DMAX 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, State Data 20a. Methed of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 5.13.00 NATIONAL 4 ☐ Donetion 5 ☐ Other (Specify) CEMETERY LAUREL, MO 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE, BALTO. 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiec or raspiratory errest, shock, or heart feiture. List only one cause on aech lina. Approximata Intervet Between Onsat and Death Immediate Cause (Finel disease or condition rasulting in death) CEREBROVAS CULAR ACCIDENT 3 WK Dua to (or as a consequenca of) ATHEROSCLEROSIS YRS Due to (or es e consequence of) HYPERTENSION; DIABETES YRS Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARCINIOMA CULON 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 1 Yas 2 No 1 Yas 2 No

Physician /Medical Examiner the attending physicien end hed for use es the bunel-trensit The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

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288-4

the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death with 1 Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 2 any injury or other traumstic avant, the Medical Department of the page 23s or 2 pages.

Funeral Director

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Physician/Medical Examiner

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To the Hospital of within 24 hours at To the Funeral D completely filled in

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated evants resulting in deeth) Last

25. Was casa rafarred to medical 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Naturat 5 Pending invastigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a, Cartifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and place, and dua to the causa(s) end mennar as atated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated.

29b. Signatura and titla of certifian

D14138

29c. Licansa number

29d. Data signed (Month, Day, Year) 5-11-2000

Baltimore MD 21216

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print)

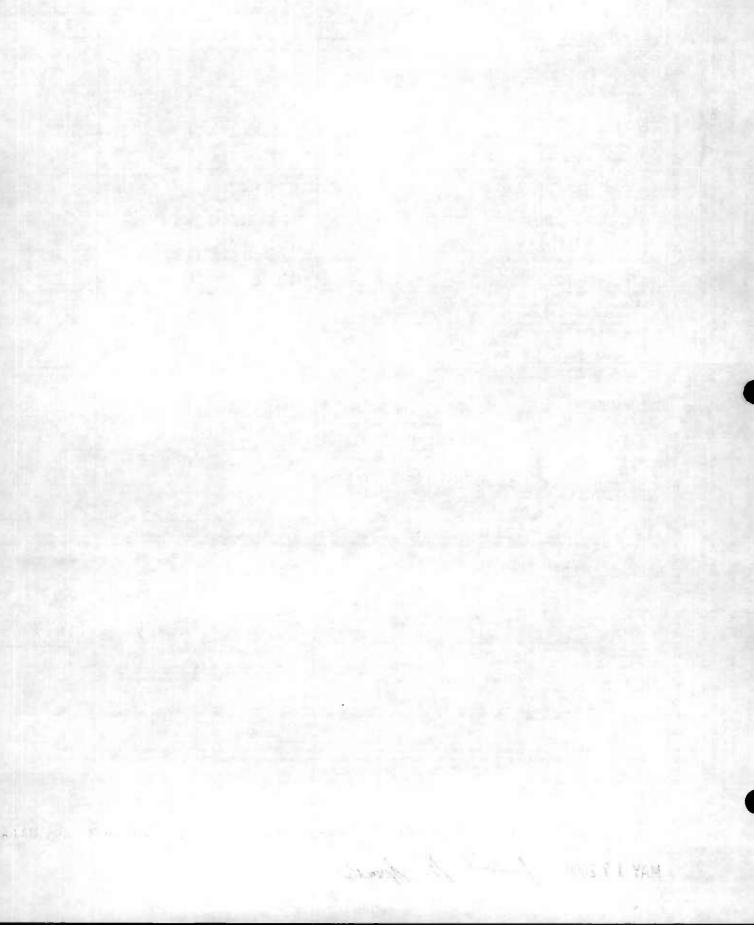
2300 GARRISON BIVE SHAFI

31. Date filed (Month, Day, Year) MAY 17 2000

32. Registrar's Şignatura

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 245 AM Month Year **Physician** ALIFORNIA YOPE 14 2000 05 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4q. County of Death Examiner NURSING LORIEN OLUMBIA If Under 24 Hrs. HOME 01 OWARD 8. Dete of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country). 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1□M 2□F 225-09-1299 Yrs. 96 Director Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No NIA Director NASEMONID VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23435 5021 TOWN POINT ROAD USA permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or hama 234 any Injury or other traumatic event, the Mentel Exerciser must public. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College:(1-4or 5+) DOMESTIC HOME 8 TH GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be THOMAS VINES CHRISTINA LEWIS 0 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9353 AFTERNOON LN., COLUMBIA, MD. 21045 ROY L. POPE SON 20a. Method of Disposition 20b. Pleca of Disposition (Name of cametery, crematory or other place) Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete ROOSEVELT MEMORIAL PARK 5. · OO CHESAPEAKE, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO, NATL' PIKE BALTO MO Approximate Intervel Between Onset end Deeth 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediate Cause (Final ehydratio/ disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner oression physician and the bunal-transit thet the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): mentia Box 68760 Physician/Medical Due to (or es a consequence of): ibdura Hematoma Pert ii. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 ☑ Unknown signed t by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 a 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death To the Hospital or Attending PI within 24 hours after death.

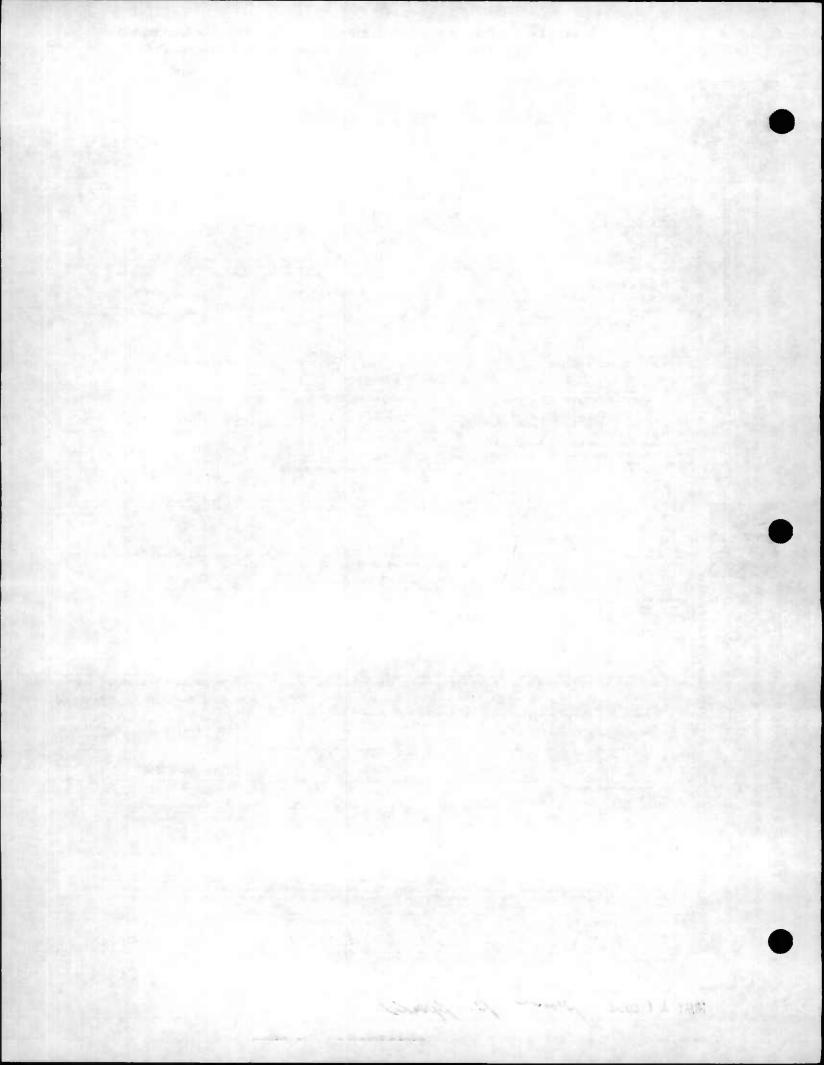
To the Funeral Director: After the completely filled in by the funara 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturat 2 Accident 5 Pending investigation 1□Yes 2□No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of or 5/15/00 D40413 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 11217 Chaucers Ridge Ct Laurel, MD Mara Sunners, MD uerite 31. Date tiled (Month, Bey, Year) 21045 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registra

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Menth 05 10 Pay **Physician** Valentine Phillips 2000 4:30pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 706 S. Bouldin Street Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** X M 20 F Days Hours Yrs 214-09-3857 Director 104 02-02-1896 Poland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director 28a-f MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 706 S. Bouldin Street 21224 USA 230 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 8 1 ☐ Yes 2 No Specify: Specify: White à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Cabinetmaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maximillian Kozlowski Unknown 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Helena Kozlowski 706 S. Bouldin Street, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) St. Stanislaus 5-14-00 Balto., MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. aerolam 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line **Physician** Atteroscleratio cardio descular discoso Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Physician/Medical Examiner attending physician end for use as the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parformed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 2 Accident 5 Pending Investigation death. 1 □ Yes 2 □ No ie Hospital or Attendi n 24 hours after death he Funeral Director: / pletely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Vietely (Check only one)

State Registrar

To the To the To the F

VINCENZO GRIPPO 31. Date filed (Month, Day, Year) 0 16 0

29b. Signature and fittle of certifier

32. Registrar's Signature

2801 FOSTER AVE

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

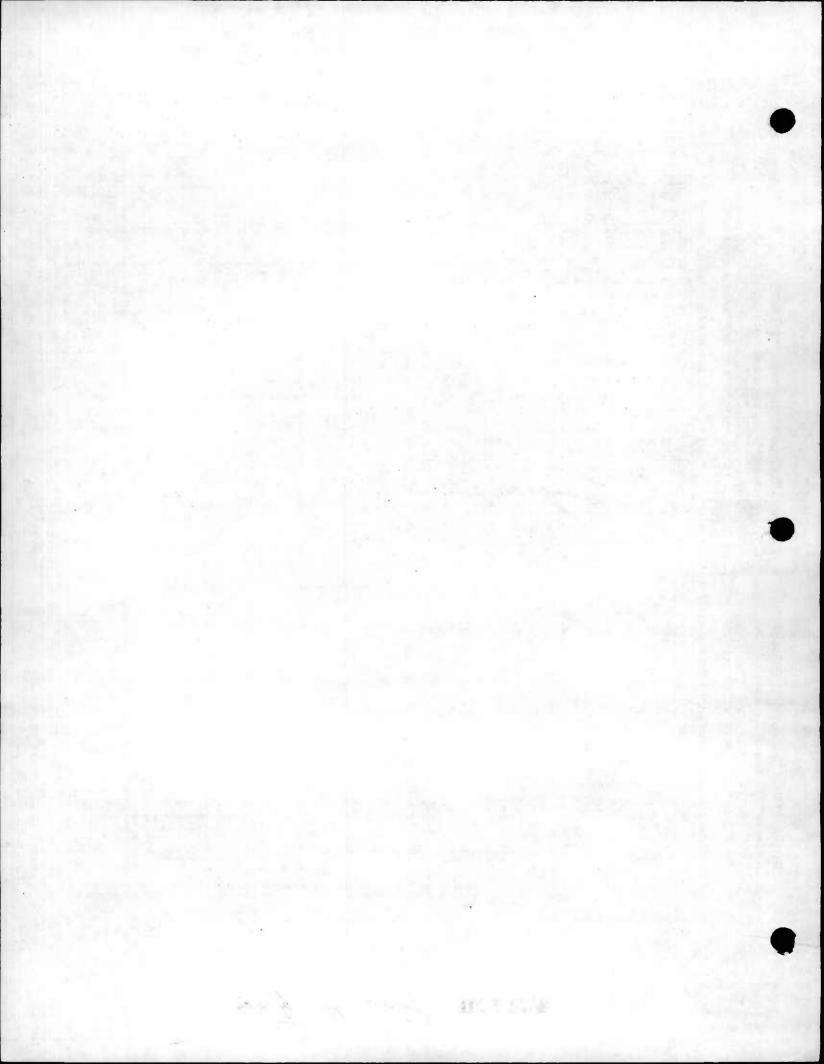
29c. License number

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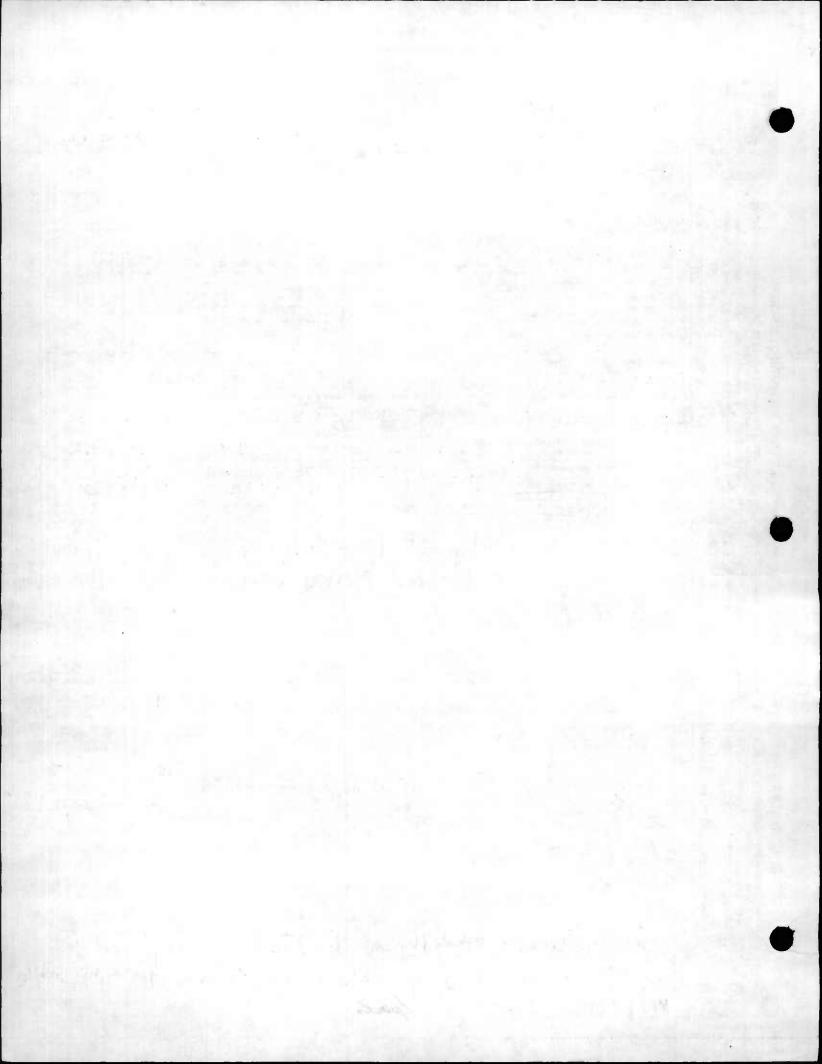
29d. Date signed (Month, Day, Year) 00

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	Certificate of Death	h Reg	. No.								
Physician	1. Decedent's Neme (First, Middle, Last)	2. Dete of Death Month	Dey Year								
/Medical	Vincentine Podlinski	May 14,	2000 8:00 A.I								
Examiner		Town, or Location of Death	4c. County of Deeth								
Funeral Director		sadena	Anne Arundel								
	140-12-2818 1 M 2X F 84 Yrs. Months Days Hours	Min. March 10,	8. Date of Birth (Month, Day, Year) Narch 10, 1916 9. Birthplece (Stete or Foreig Country) Penn.								
natural, or items 23s or 28s-1 show sized Examiner must be notified at steed by Funeral Director	Usuel Residence of Decedent 10a. Slete 10b. County 10c. City, Town or Location		10d. Inside City Limit								
or items 23s or 28s-f show entree must be motified at / Funeral Director	Now Jones Candon Bannesukan		1 ☐ Yes 2 💢 No								
for matternesses of 284-fa	New Jersey Camden Pennsauken 10a. Street and Number 100. Zip Code	100	10g. Citizen of What Country?								
2 0	7291 Githens Avenue 08109		U.S.A.								
2 2 2	11 Martiel Status 12 Was Decadent Ever in U.S. 13 Was Decadent of Historic O	Origin? (Specify Yes or No-	14. Race - American Indian,								
F P	1 Never Merried 2 Merried 1 ☐ Yes 2 No		Black, White, etc.								
- H - 6	3 Wildowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify	у:	Specify: White								
ygiene. Nor than *natural*, It, no the discal Ex-	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during mo	not of working	b. Kind of Business/Industry								
	(Specify only highest grade completed) (Give kind of work done during mo	ost of working									
c than Comp	Unknown 0 Tavern Owner		Liquor								
and Mental Hyginaria marked other aumatic event, I			s Neme (First, Middle, Meiden Surneme)								
Mental I arked or atic eve	Frank Rosinski	Unknown Kry	wn Krynski								
D E E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)	ber or Rural Route Number, (City or Town, Stete, Zip Code)								
M Heelth Kern 27 other tr	Christine Burleigh (Daughter) 7291 Githens Ave	enue Pennsauke	n, N.J. 08109								
H Per y	20e. Method of Disposition 20b. Place of Disposition (Nama of completely, crametory or other place) 20b. Place of Disposition (Nama of completely, crametory or other place)		c. Location - City or Town, Steta								
ment:	4 Donation 5 Other (Specify)		nnsauken, N.J.								
Department of Heelth end Mental Hygiene. mportant: if Item 27 is marked other than any injury or other traumatic event, the Mance. To Be Comp	21. Signature of Fungral Service Licensee Kevin E. Ecker McCuriy-Polyni	ak Funeral Ho	me. P.A.								
05 \$ 9	3204 Mountain F	Road Pasadena,	Maryland 21122								
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such e shock, or heart tellure. List only one cause on each line.										
nysician	Grown, or real tollide. East only on a code of good line.	1	Onset end Death								
Medical xaminer	Immediate Ceuse (Finel disease or condition a. haliquant Mesotheli	MAC.	11 root								
	rasulting in death) a. Due to (or as e consequence of):	and	11 Indition								
	10th and alound	atheis on	11 went								
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ien a	if any, laading to immediate cause. Enter Underlying	equentially list conditions, any, laading to immediate ause. Enter Underlying ause (Disaase or injury c.									
physicie is the bur edical	Cause (Disaase or injury C. thet initieted events posulting in death) Last Due to (or as a consequence of):										
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d by the ettending etached for use a Physician/M	Pert tl. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert	t t. 23b. Dtd toba	acco use contribute to the cause of deat								
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be d											
page 2 should be det		24a. Was an a	d? aveilable prior to								
2 C L		_	completion of cause of death?								
certificate he rector, page		1 ☐ Yes	22 No 1 □ Yes 2 No								
pertificate rector, pag	25. Was case referred to medical 26. Plac	ce of Death (Check only one)									
# 8 2	axaminer/	Nursing Home 5 ☐ Rasiden	ce 6 Mother (Specify) Danshit								
21.00	27. Menner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28c. Injury at Work?	28d. Describe how	injury occurred								
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er de esto by th	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be detarmined 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify)		28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)								
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Non Inch	29a. Certifier Continue Physician: To the best of my knowledge, death occurred at the time, data a	and place, and dua to the cau	se(s) and menner as stated.								
within 24 hours To the Funeral completely filled	Check only 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, da and menner steted.	atn occurred at the time, data	a and place, and due to the cause(s)								
E	29b. Signature and title of certified 29c. License number	290	. Date signed (Month, Dey, Year)								
\$ # 8 N	I NOW HE THORE ON AHOUR QUELLE DETTING MILLE TOWN										
E B V	Collet March March Physical 1/52	30. Name and address of person who completed cause of death (htery/23a) (Type, Print)									
Tothe	30. Name and address of person who completed cause of death (Negro 23a) (Type, Print)	10 4	24101200								
A CO	30. Name and address of policion who completed cause of death (Herry 23a) (Type, Print) Nohry t. Logue M.D. 479 June 16 Pour Dead	#204 Sover	My Perkmi ZIH								
State	30. Name and address of person who completed cause of death (Negr/23a) (Type, Print) Short Loque (U.) + 19 Junes Hole Read 31. Date filed (Month, Day, Year) 32. Registrar's Signature	#304 Seve	ne Perkmy 214								



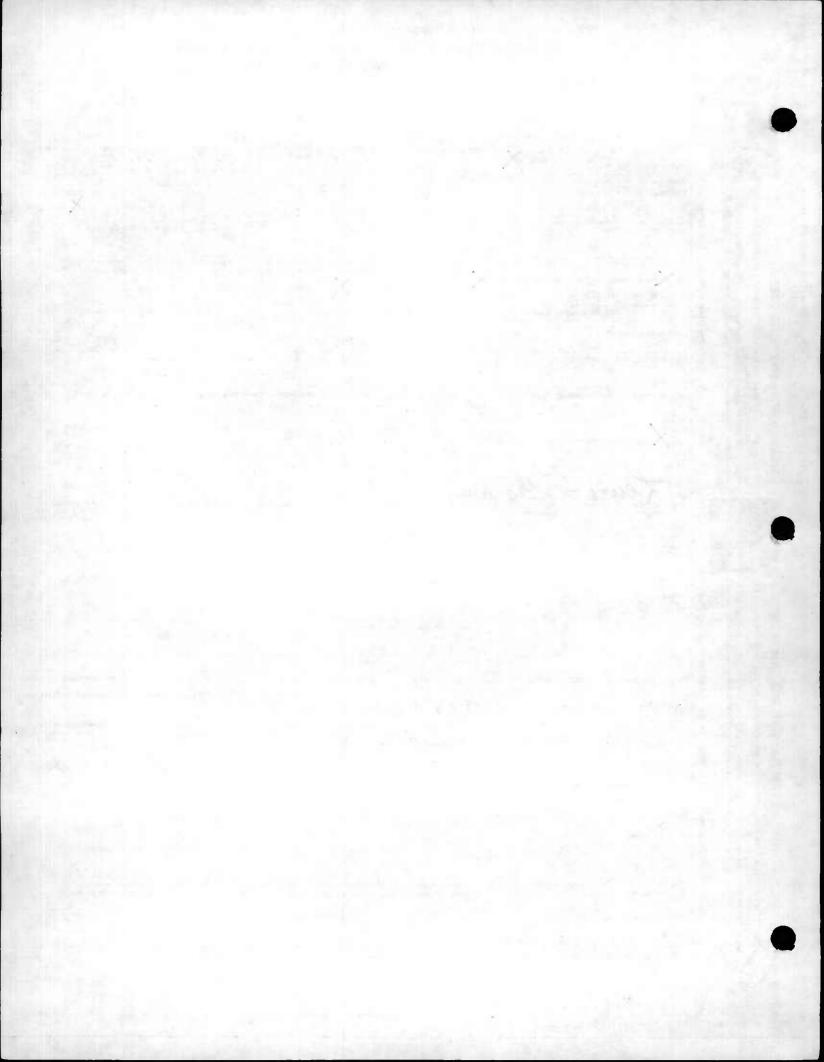
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Year **Physician** PHYLLIS A PETERSON 4b. City, Town, or Location of Death 11 2000 10:45 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BALTIMORE N/A Hospital of Baltimore Sinai Months Days Hours Min. DEC. 12, 1957 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MARYLAND 5. Social Security Number 6. Sax **Funeral** 1 M 2 F Months 42 214-78-7977 Yrs. Director Usuel Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits or flems 23s or 28s-f show univer must be notified at Yas 2□No Director MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 900 CHAUNCEY AVENUE 21217 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas 2 1 Yas 2 No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 1□ Yes 2 No natural, or Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working lifa. DO NOT use retired) Elamentary/Secondary (0-12) Collega (1-4or 5+) 12th N/A CANDY/NUT PACKER DRY GOODS 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) permit. Peges 1 and 2 should be f Department of Heelth and Mental I Important: If Item 27 is marked of any Injury or other traumatic eve ELIZA SPENCE CARLTON PETERSON 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3819 BARRINGTON ROAD.BALTO.MD.21216 ELIZA PETERSON-MOTHER 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata KING MEMORIAL PARK 5/18/00WOODLAWN, MARYLAND 21. Signatura of Funaral Sarvice Licensee LEWIS T. GWYNN 22. Nama and Address of Facility LEWIS T.GWYNN FUNERAL 4517 PARKHEIGHTS AVE.BALTO.MD.21215-6393 Luchn Approximata Intervel Between Onset and Death 23a. Part. Enter the disease, or complications that eased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause pro each line. **Physician** /Medical Immediata Causa (Final Distress Syndrome Respiratory disaese or condition resulting in deeth) Examiner Dua to (or as a consequence of): Physician/Medical Examiner Endocarditis I or Attending Physician: The lew requires thet the deeth certificate be executed that death.

Director: After this certificate has been signed by the attending physicien and in by he funeral director, page 2 should be detected for use as the burial-transit in by the funeral director, page 2 should be detected for use as the burial-transit. Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as e consequence of) Box 68760 Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Acute renal failure, HIV, Hepatitis C Records, 24b. Were autopsy tindings available prior to Be Completed 24a. Was an autopsy performed? Iteroin and cocaine abuse, Anemia completion of cause of death? 1 Tes 20 No Division of Vital 25. Was case rafarred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 TYas 2 No 2 Accident investigation 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) May 11, 2000 P12304 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) -0 Sinai Hospital of Baltimere C. Barno MO 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura Stale MAY 1 7 2000 Registra

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #31 PER 31 PER V.R. G783 5-17-00 WR. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Daath Month **Physician** RONALD PATTERSON MAY 2000 11:05pm 14 /Medical 4a. Facility Nama (If not institution, give straat and numbar) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** CARE FUTURE NURSING RANDALLSTOWN CENTER BALTIMORE If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country)
DEC.30,1944NORTH CAROLIN 7. Aga (In yrs. last birthday) **Funeral** Days Months 216-42-9179 55 Director CAROLINA Usual Residence of Decadent 10a, Stata 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at N/A MARYLAND BALTIMORE 1X Yas 2 No Directo or 28a-1 10e. Straat and Numbar 10f. Zip Code 10g. Citizen of What Country? 23a 3808 REISTERSTOWN ROAD 21215 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 M No If Yes, Giva Yaar or Datas: thems 11. Marital Status Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indien, Black, White, etc. 1 Navar Married 2 Marriad 8 1 Yas 2 No Specify: þ Specify: **BLACK** 3 Widowad 4 Divorcad Completed 15. Decedant's Education (Spacify only highest grada completed) 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12th N/A LONG SHOREMAN STEAMSHIP TRADE 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Mental and 2 should be marked UNKNOWN WILDA B. Department of Health and Milmportant: If them 27 is mark any injury or other traumed 0005. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town, Steta, Zip Coda) RONNETTE ATKINS-DAUGHTER 3808 REISTERSTOWN RD.BALTO.MD.21215 Baltimore, 20b. Placa of Disposition (Nama of camatery, cremetory or othar placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data Burlal 2 Cramation 3 Removal from State MOUNT ZION CEMETERY 5/17/00 LANSDOWNE, MARYLAND 21. Signature of Puneral Service Licansee GWYNN Ama and Addrass of Facility LEWIS T.GWYNN FUNERAL LEWIS T HOME 4517 PARKHEIGHTS AVE.BALTO.MD.21215-6393 23e. Part 1. Enter the disease, or complications that you set the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on the line. Approximata Intarval Batwaen Onsat and Daath Physician COLON GANCER /Medical Immadiata Ceusa (Final disaasa or condition rasulting in deeth) Examiner Dua to (or es a consaquence of): Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Causa (Diseasa or injury that Initiated avants rasulting in deeth) Last Bud Dua to (or as a consequence of): De exect Division of Vital Records, P.O. Box 68760, physician Physician/Medical requires that the death certificate Dua to (or es e consequance of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 € Caknown ģ 24b. Wara autopsy findings evellebla prior to complation of causa of death? Completed 24a. Was an autopsy performed? The law 1 Yas 2T No 1 ☐ Yas 2 ☐ No Be 25. Was case rafarred to medical 26. Pleca of Daath (Chack only one) Othar: 4€ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 2 No Hospital: 2 1 Inpatiant 2 ER/Outpatient 3 DOA SE SE 27. Mannar of Daath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Dascribe how Injury occurred Affer 5 Panding Invastigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be datarmined 3 ☐ Suicide 28a. Plece of Injury - At home, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Straet end Number or Rural Route Numbar, City or Town, Steta) 4 Homicida To the Hospital with 24 hours a To the Funeral D Tertifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end place, and dua to the ceuse(s) and menner es stated.

| Medical Examiner: On the basis of axaminetion end/or invastigetion, in my opinion, daath occurred at the time, date and place, and dua to the ceusa(s) and manner stated. edical 29a. Cartifiar (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year)

State Registrar 31. Dete filed (Month, Day, Year) MAY 1

30. Nama and address of person who complated causa of daath (Itam 23a) (Typa, Print)

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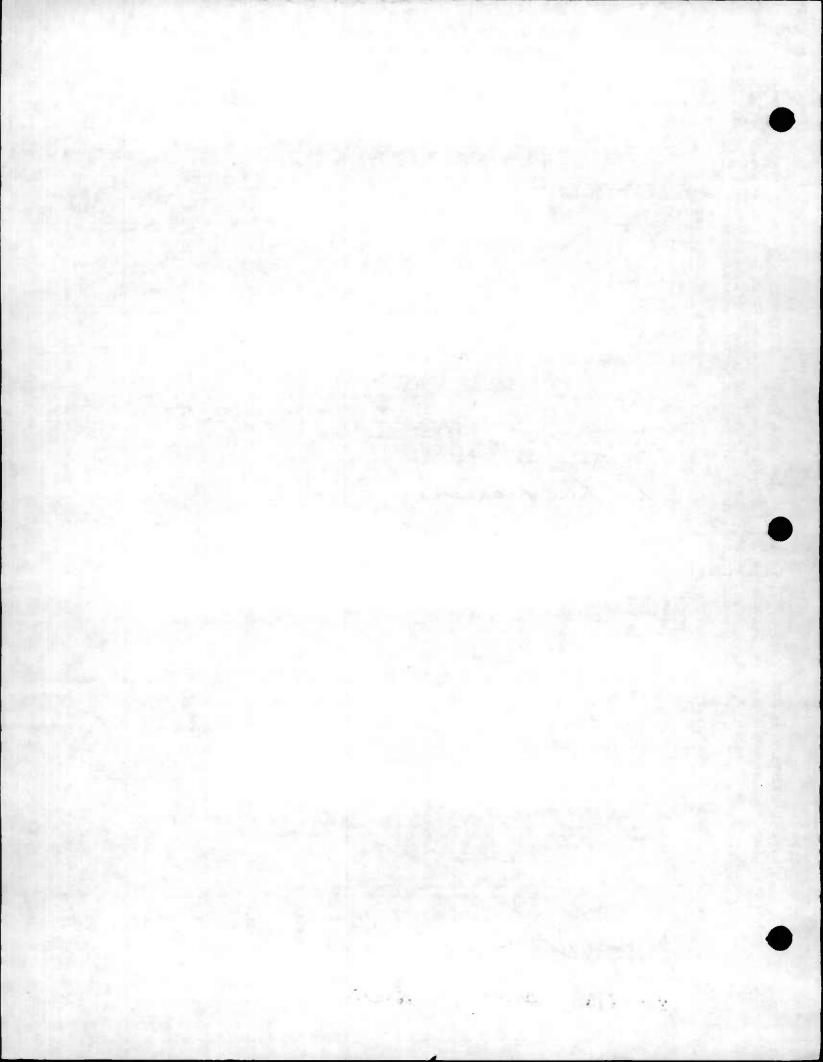
Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene | 5808

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Registrar



Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0849 5 00 arr /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ff Under 1 Year | ff Under 24 Hrs. allston (seneral artord 8. Date of Birth O'Month, Day, Dec. 9, 7. Age (In yrs. lab) 9. Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Y97945 Months Days Hours 1 M 2□ F 54 Yrs 219-44-8195 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mentel Hyglene. Important: If item 27 is marked other than *natural', or items 23e or 28e-f ahow enty injury or other traumatic event, ins langual Exercities must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Fallston Harkord 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 1006 Sturbridge Road 21047 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) years Petroleum Engineer Petroleum Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry A. Pafel, Sr. Minnie Elizabeth Trout 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Pafel (Wife) 1006 Sturbridge Road. Fallston, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Entombrent Bel Air Mem. Grans Maus! 5/19/00 Bel Air. Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Marie 610 W. MacPhail Road, Bel Air, MD 21014 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel hour disease or condition resulting in death) 11 an Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 080 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Medical Certification: To this After t 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 fours after death.
To the Funeral Director: After the Funeral Directors of the funeral in by the fur 1 Natural 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rock W. Walken 2005 torest 40

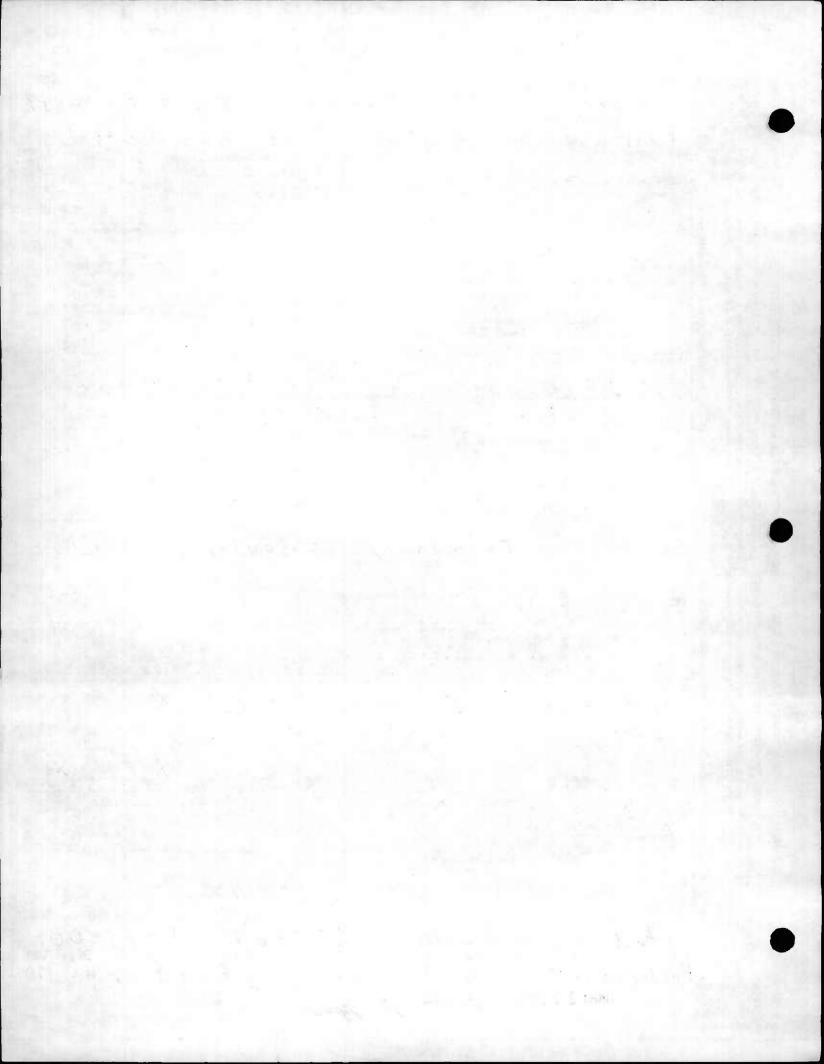
Registrar

State

31. Date filed (Month,

32. Registrar's Signeture

7



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death **Physician** May 11, JEROME CLAIRE PAUL 2000 1:50 p.m. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 302 L. Canterbury Road Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 20, 1925 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Yrs 219-18-8803 Director 74 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f Director Maryland Harkord Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 302 L. Canterbury Road 21014 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 DYes 2 No If Yes, Give Yeer or Detes:1 943-45 1 Never Married 2 Married Saltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) 12th grade Steel Company Foreman parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Tem 27 is merked othe any injury or other traumatic event once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Bert Paul Mary Harhin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 L. Canterbury Road, Genevieve Paul (Wixe) Bel Air, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Veterans Cem. 5/17/00 Owings Mills. MD 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signatur@oliFuneral Service Licens 610 W. MacPhail Road, Bel Air, MD 23a. Peril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or as e consequence of): Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of) Box P.O. I 23b. Did tolesco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ NO certificate To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Diractor: Affer this certifica completely filled in by the funeral director, p. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only) Other: 4 Nursing Home Medical Certification: To 1☐ Yes /2DM 5 Naesidence 6 □Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manney of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Wetural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

State Registrar

29a. Certifier (Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERR

32. Registrar's Signeture

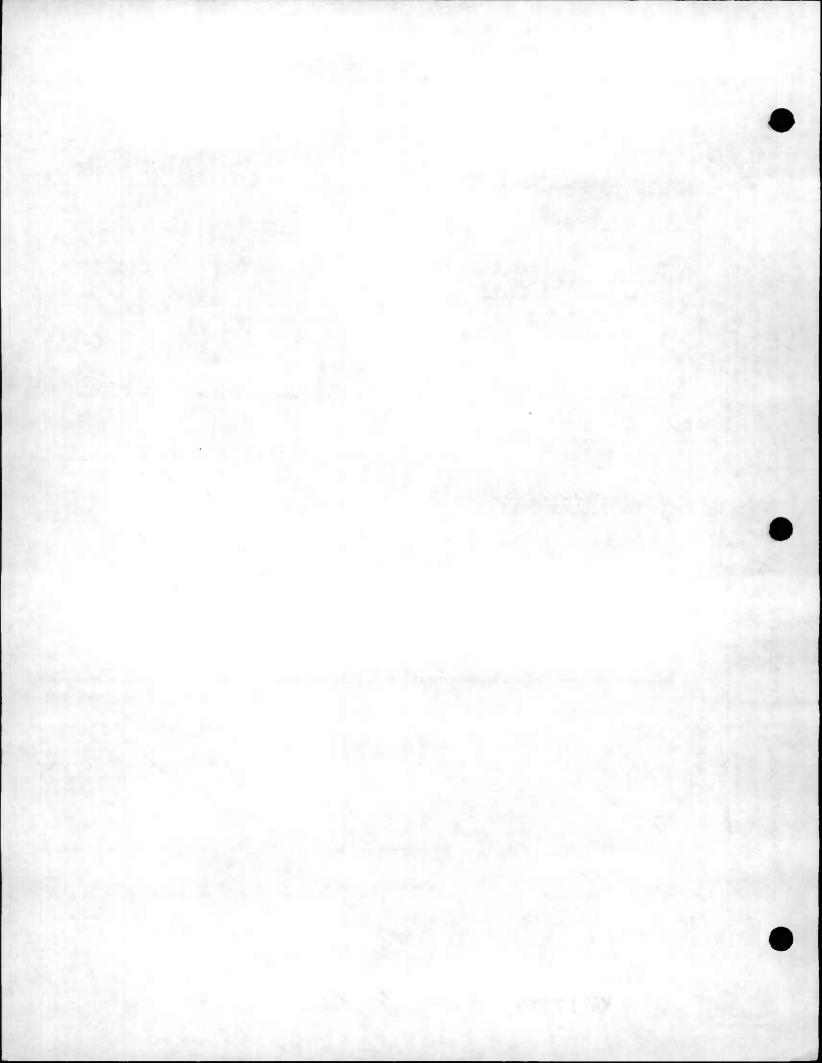
DHMH 16 Rev 6/95

1 ertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated.

29c. License number

29d. Dete signed (Month, Day, Year)

ATREE RD., SUITE 115, BEL ATR, 4021014



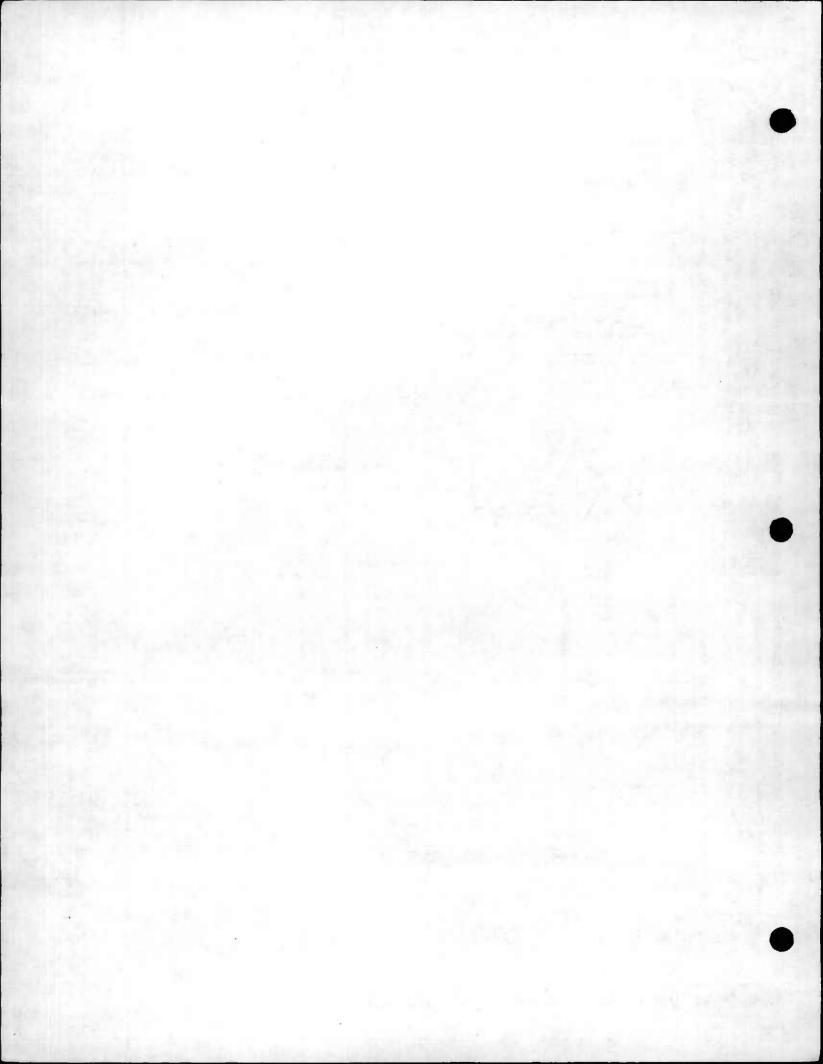
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State of Maryland / Department of Health and Mental Hygiene | | 5 8 | |

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Exami		4a Facility Name (If not institution,	give street and number	r)				4b. City, Tov	wn, or Lo	ocation of Deeth	4c. County	of Death	
0 -		Fallston Genera	l Hospital					Falls.			Harf	ord	
Funeral Director		5. Social Security Number 220-38-6077		ige (In yrs. 77	last birthda Yrs.	Month	er 1 Year Days		24 Hrs. Min.	8. Date of Bird (Month, Da March	у уваг) 5, 1923	9. Birthpl Goun Ital	lece (Stete or Foreign ly) Y
2 ,		Usual Residence of Decedent		140.00		1 mailion							
ah ya	-	10a. State 10b. County			ty, Town or							10	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
W T	ç	Maryland Harfo	rd	Ab	ingdo	-							1 Hes ZINO
₽ 9 F	5	10e. Street and Number		10f. Zip Code								10g. Citizen of What Country?	
23 b	-	3000 Pouska Roa	d				21009			u.s.A.			
Maryland 21215-0020 d 2 should be filled within 72 hours after death with the Maryland th and Mental Hygiene. T is marked other than "natural", or items 23s or 28s-4 show traumatic avant, tre Medical Exeminar must be notified at	ior than "natural", or flows 23s or 28s-f show it, the Medical Examiner must be notified at Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Wes Deceden Armed Forces d 1 Yes 2 (X If Yes, Give Year or Dates	? Í No	I,S. 1	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto □ Yes 2♥ No Specify:			ecify Yes or No Rican, etc.)	- 14. Rad Blad Specify	ck, White, o		
2 ho	P	15. Decedent's	Education	ducation			ual Occu	pation			16b. Kind of B	usiness/inc	lustry
Naryland 21215-002 2 should be filled within 72 hours 1 and Mental Hygiene. Is marked other than "natural", reurmatic avent, the Medical Ex-	ple	Elementary/Secondary (0-12)		completed) College (1-4or 5+)			use retire	during most d)	OF WORK	ing			
Magaria	- PO	12th grade			Clothing 1		Designer				Clothi	ng	
D # £ # £	Be	17. Father's Name (First, Middle, Li	est)				1-1	18. Mother	r's Nem	e (First, Middle,	Maiden Sumen	10)	
Aente de la la la la la la la la la la la la la	To	Giovanni Polino Ro.							a (Unknown	1)		
of Series		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Ma	iling Addre	ss (Stree	and Numbe			er, City or Town,	Stete, Zip	Code)
M nd 2		Rosanna Hisley	(Dahtr)		31	05 Pou	ıska	Road.	Ab	ingdon.	MD 21	009	
ire, Maryland 212: s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other treumatic avent, tre 18		20a. Method of Disposition		20b. I		sposition (N			1	Dete	20c. Location		wn, Stete
Pege nat: If		1 🕅 Burial 2 Cremetion 3 4 Donation 5 Other (Spe	ocify)	9		n Cem	eteri	у		5/16/00	Baltim	ore,	Maryland
Demit. Department importations		21. Signature of Funeral Service Li	M			Schimu 610 W.	inek Mac	Funera Phail	al H Roa	lome of	Bel Air Air, M	, Inc	014
		23a. Part1. Enter the disease, or or shock, or heart failure. List or	omplications that cause	ed the dea	th. Do not	enter the me	ode of dyi	ng, such as	cardiac	or respiratory a	rrest.	1	Approximate Intervel Between
Physician /Medical		Immediate Cause (Final	41					,					Onset and Deeth
Examiner		disease or condition resulting in death)	· Myoca	9/2d/	α .	INTE	test,	س					12 nes
	- I	Due to (or as a consequence of):											
De tied	든		b. — Due to (or as a consequence of):										12.50
death certificate be associted e attanding physician and ed for use as the bunal-transit	×	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):										
68760, ficate be an physician as the bunal	10	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of):										ì	
the cate	을											i	
X STEEL STEE	Ne Se		- d	d									
BOX eath cer attendin	2		0										
The add	9	Part II. Other significant conditions	significant conditions contributing to death but not resulting in the underlying cause give					given in Part I.		23b. Did tobacco use contributs to		the cause of death?	
law requires that the deas been signed by the a	Physician/Medical Examiner								10	1 Yes 2 No 3 Proba			
Signe De c	by									-			
OT VI(al HECOYGS, Physician: The law requires the ribis certificate has been signe ral director, page 2 should be	e de	Parties and the same									en eutopsy rmed?	ava	ere autopsy findings allable prior to
has b	호											of	mpletion of cause death?
Page H	s certificate director, pag To Be Co									10	Yes 20 No	10	Yes 2₽No
Tallon Title		25. Wes case referred to medical						26. Place of D		h (Check only o	ne)	1	
Of VITA Physician: this certific ral director,		examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 22	ER/Outpat	ient 3 [OOA OI	her: 4 Nu	rsing Ho	me 5 ☐ Resi	dence 6 □Oth	ner (Specif	v)
O H Tal		27. Manner of Death	28a. Date of In (Month, D			28c. Inju		T		how injury occur			
thanding P death. for: After the funan	읖	1 [*] □Natural 5 □ Pending 2 □ Accident investiga		ely rear)	Year) Injury M			Work? 1 ☐ Yes 2 ☐ No					
OVINION Tor Attending after death. Director: After Jin by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no	ari 208. Placa of II	28e. Placa of Injury - At home, farm, street, factory, office						28f. Location (Street and Number or Rural Route Number,			
2 4 5 E	Le	4 Homicide	building, e	rtc."(Speci	(y)	CLC I TILL				281. Location (Street and Number or Rurel Route Number, City or Town, State)			
To the Hospital or Atta within 24 hours after de To the Funeral Directo completaly filled in by th	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best	of examina	wledge, de ition and/or	ath occurre investigation	d et the ti	me, date encopinion, deat	d placa, th occur	and due to the red at the time,	cause(s) and madate and place,	anner as st	tated. the cause(s)
thin	M	29b. Signature and title of certifier	and manner s	water.		9	9c. l iran	sa number			29d. Date signe	d (Month	Day Year)
F 3 F 8									PI	7			
		13 alac (Many), 10 H 0053869									5//6/	200	U
M		30. Name and address of person, who	TUNKA	death (Iter	m 23a) (Typ	Print)	AUE	F	7//5	ton s	21047	,	754
St	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Sign	ature	1.	1	,					
Regist		MAY 1 7	2000 5	ener	1	9 1	100c	Ka					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	M: #2 PER PHY G783 1. Decedent's Name (First, Middle, Last		Certificate o	Dealli	2. Date of De	Reg. No.	5 3. Time of Death	
Physician /Medical	Louis Rudolph P	ohlner			Month	The 20	Year	
Examiner	4a Facility Name (If not institution, give	11	0		or Location of Deat	h 4c. County		
	NORTH ARUI 5. Social Security Number 6. Se	VDEC 1-05P17 x 7. Age (In yrs. last		1 14	SURNIE Irs. 8. Data of Bi	44	COUNTY	
Funeral Director		ØM 2□F 54	Yrs. Months Day		in. (Month, Di	ay, Year)	Birthplace (State or Foreign Country) Mary land	
	Usual Residence of Decedent 10a. State 10b. County	100 City T	own or Location		11103 10			
nothing at							10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
Director	Maryland Anne Ar 10e. Street and Number	undel I Pas	adena 10f. Zip Code)		10g. Citizen of		
a D	478 Center Street		2112	22		USA		
Funeral	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent o	f Hispanic Origin? uban, Maxican, Pu	(Specify Yes or No erto Rican, atc.)	o- 14. Rad	ce - Amarican Indian, ck, Whita, atc.	
by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Ves 2 No 1963 If Yes, Give Year or Dates: 1968	- 1□ Yes 2□XN	lo Specify:		Specif	w: White	
	15. Decedent's Edu	cation 1	6a. Decedent's Usual Occ	cupation	Course Course	16b. Kind of B	usinass/Industry	
Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work dor life. DO NOT use reti Security Gu	ired)	vorking	Cocumi	+.,	
S	10 17. Father's Name (First, Middle, Last)		Security di		lama (Final Adiabella	Securi		
To Be	Louis R. Pohlner			Grace	M. Joy		na)	
F	19a. Informant's Name/Relationship (T)	rpe, Print)	9b. Mailing Address (Stre				State, Zip Code)	
To Be Com	Margery D. Pohlne	r	478 Center	Street,	Pasadena	, MD. 21	122	
	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F	come	of Disposition (Name of stery, crematory or other p	olace)	May 19	20c. Location	City or Town, State	
	4 □ Donation 5 □ Other (Specify)	Mt.	Carmel Cemet		2000		na, Maryland	
any injury o	21. Signature of Funeral Service Ligens	2.	3111 MOur	ress of Facility Itain Rd.	Stalling , Pasade	s Funera na, MD.	1 Home, P.A. 21122	
	23a. Part1. Enter the discusse, or compleshock, or heart failure. List only o	ications that classed the death. December 1	o not enter the mode of d	lying, such as card	liac or raspiratory a	arrest,	Approximate Interval Between	
ian ical	Immediate Cause (Final	MU	1 0 1	110.0	Or TI	N C	Onsat and Death	
ner	disease or condition resulting in death)	MYGEAR	JIAL 1	IUTITI			30 als	
e e		Due to (or as	a consequence or:	RTRY	Dese	ase !	A -	
al Examiner		V	a consequence of):	1				
<u>e</u>	Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o			9 -			
clan/Medical	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
clan	Part II Other elgolificant conditions co	stelly sting to doubt had not moulting		alian in Badd	ash Did	lankana ukkan		
Physic	Part II. Other significant conditions con	A D B MA I A	g in the uncertying cause	given in Part I.		Yes 2 No	ntribute to the cause of death? 3 Probably 4 □ Unknown	
by F	HYPALIV	18 BINCTIA	The state of					
Completed by Physician/M	Merry	Obesily	1		24a. Was perfe	an autopsy ormed?	24b. Were autopsy findings available prior to completion of causa of death?	
Сомр					10	Yas 20 No	1 Yas 2 No	
8	25. Was case referred to medical axaminer?				Death (Check only	ona)		
Certification: To Be Co	1 Yas 20 No		Outpatient 3E DOA		Homa 5□Ras			
	27. Manner of Death 1 Natural 5 Pending	28a. Date of tnjury (Month, Day Year) 28i	tnjury M 28c. fn	jury at /ork? □ Yes 2 □ No	28d. Describe	how injury occur	red	
by the	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,			28f. Location	(Street and Numl	ber or Rural Route Number,	
din din	4 Homicide	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,			wn, Stata)		
Medical C	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my knowled ner: On the basis of axamination and manner stated.	ige, death occurred at the and/or investigation, in my	time, data and pla y opinion, daath oo	ace, and dua to the courred at the time,	causa(s) and ma , data and place,	annar as stated. and dua to the cause(s)	
completely filled in b	29b. Signature and title of certifier	were tree with with the	29c. Lice	nse number		29d. Date signe	d (Month, Day, Year)	
	Nasho	Ch Ch	217	737		5-	15-00	
	30. Name and address of person who co	empleted cause of death (Item 23)	a) (Type, Print)	7	2 11	- /	15-00 CB 21061	
0	14. KASTOBI	m 73	575 K	ITCHI	5 /te	07/14	15 2000	
State Registrar	31. Date filed (Month, Day, Year) MAY 1 7 2000	32. Régistrar's Signature	foods			-		



Physician /Medical Examiner physician and s the burief-trensit Box 68760.

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral', or itema 23a or 28a-f ehow Examiner meat be notified at

10.

Director

Funerai

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Completed

Be

2

with the Merylend

death

Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mentel Hyglene.

is marked other

Depertment of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eva pace.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner the th þ Completed page Be edical Certification: To To the Hospital or Attanding Pt within 24 hours after death. To the Funeral Director: After it completely filled in by the funera

Division of Vital Records, P.O.

	Hypertensic	on			Years
Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying	Due to (
Cause (Disease or injury that initiated events resulting in death) Lest	Due to (d				
Part II. Other eignificant conditions of Seizure disorder	ontributing to death buf not res	sulting in the underlying	cause given in Part I.		ontribute to the cause of death?
alcohol abuse, ci	rrhosis			24a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?
colon carcinoma				1 ☐ Yes 2 🔀 No	1 ☐ Yes X☐ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 🕅	ER/Outpatient 3 0	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ot	her (Specify)
27. Manner of Death 1 Naturat 5 □ Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of tnjury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occu	rred
3 Suicide 6 Could not be determined		ome, farm, street, lactory)	ory, office	28f. Location (Street end Num City or Town, Stete)	ber or Rurel Route Number,
29a. Certifier Check only 2 Medical Example	ysician: To the best of my knoniner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and plec on, in my opinion, death occ	e, and due to the cause(s) and m curred at the time, date and place,	nanner as stated. , end due to the cause(s)
20h Signature and to of continu		2	On License number	20d Date sign	ad (Month Day Your)

State Registrar **DHMH 16 Rev 6/95**

31. Date

Loch Raven Blvd.

rson who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

MD 5601

Baltimore, MD 21239

May 15, 2000

Mollman, MP D257:53 - Non 5, 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month Year 8.15 AM **Physician** A - ROBINSON KATIE 10 2000 05-/Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE NIA WAY APT. DENVIEW If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10 M 20 F 217-34-2719 Yrs. SC Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryla: the Medical Examiner must be notified at 1 Yes 2 No MD NI BALTIMORE Directo berns 23s or 25s-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? WAY APT. 21206 DENVIEW Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Montal Hygiene. Improprient if them 27 is marked other than "natural", or list Yes 2 No 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: py 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE 8 TH GRADE EALTH 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCODARD 2 AMANDA GASTON JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) KOBINSON VIVIAN 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State 5-12-00 BALTIMORE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility CREMATION SERVICE. METRO CREMATORY 5151 BALTO. NATL' PIKE, BAUD. MD. 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final 2ax disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Due to (or as a consequence of): P.O. Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 8 100 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by page 2 should be 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? certificate has 3/1NO 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicat 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Statesidence 6 Other (Specify) Certification: To After this 28a. Date of injury (Month, Day Year) 27. Magner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 | Natural 2 | Accident 5 Pending investigation aftar death.

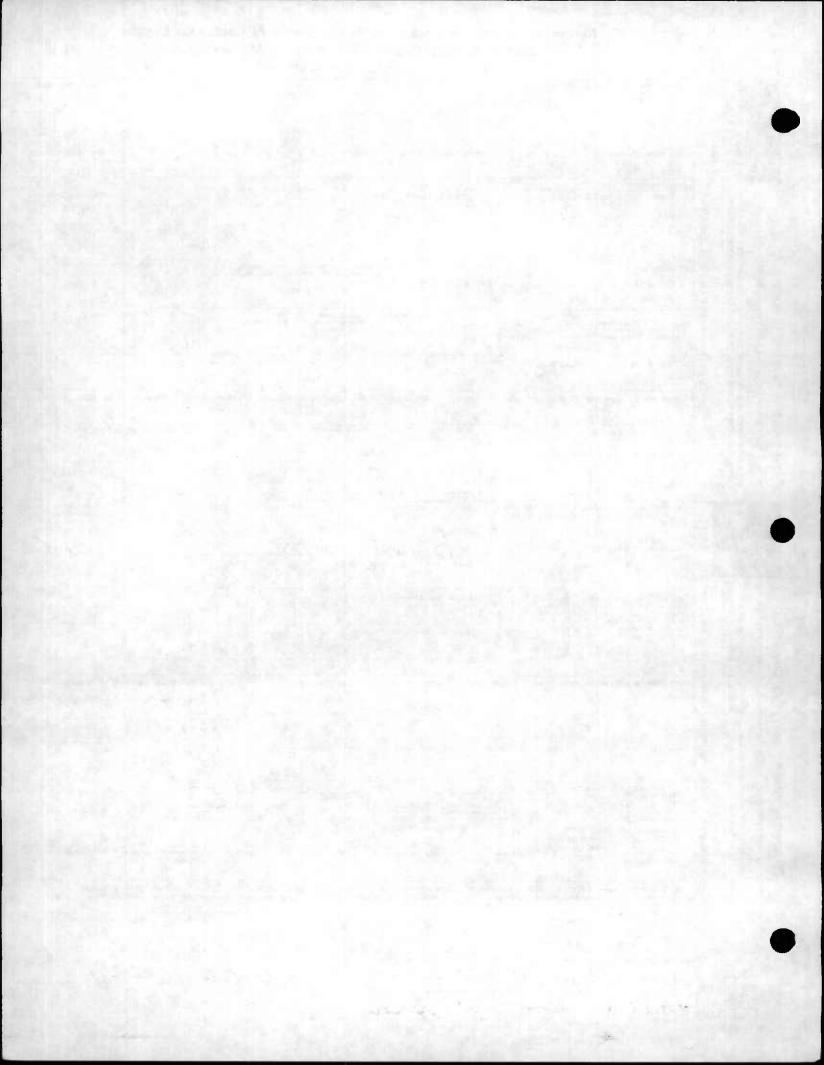
I Director: Aff 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier completely within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and little 29c. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO 21204 656 N. Charles 31. Dete fited (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

MAY 1 7 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 13, 12:15 p.m ANITA DENISE SCOTT MAY 2000 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5508 BELLE AVE BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUNE2, 1953 9. Birthplace (State or Foreign Country) MARYLAND 6. Sex 1□ M 2XF **Funeral** Months Days Hours Yrs. 216-66-9400 46 Director Usual Residence of Decedent 10a. Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 12 Yes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 238 5508 BELLE AVE. 21207 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1□ Yes 2 No 3altimore, Maryland 21215-0020 ò Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementery/Secondary (0-12) College (1-4or 5+) 12th N/A WORKER STOCK SHIPPING/RECEIVING 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be and 2 should be saith and Mental JAMES H. BARNEY SHIRLEY SCOTT 19e. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau page. . SHIRLEY S.MANNING-MOTHER 5508 BELLE AVE. BALTO.MD.21207 20e. Nethod of Disposition 1 Burial 2 Cremetion 3 Removel from State Donetion 5 Other (Specify) 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete ARBUTUS MEMORIAL PARK5/19/00 BALTO.MD. 22. Name and Address of Facility 21. Signeture of Europeal Service Licensee LEVIS T.GWYNN LEWIS T.GWYNN FUNERAL HOME mu 4517 PARKHEIGHTS AVE.BALTO.MD.21215-639\$ 23a. Pert1. Enter the disease, or complications that occused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** tmmediete Ceuse (Final diseese or condition resulting in death) /Medical Examiner Physician/Medical Examiner bunial-transit The law requires that the death certificate be executed Sequentietly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician the buria Box 68760, Due to (or as a consequence of): P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 2 24b. Were eutopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medicat exeminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Neturel 2 Accident 5 Pending death. investigetion 1 Yes 2 No hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 4 Homicide A 24 hou. Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) To the Fr To the within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

& var ECHOMP, 22 South 31. Dete fited (Month, Day, Year)

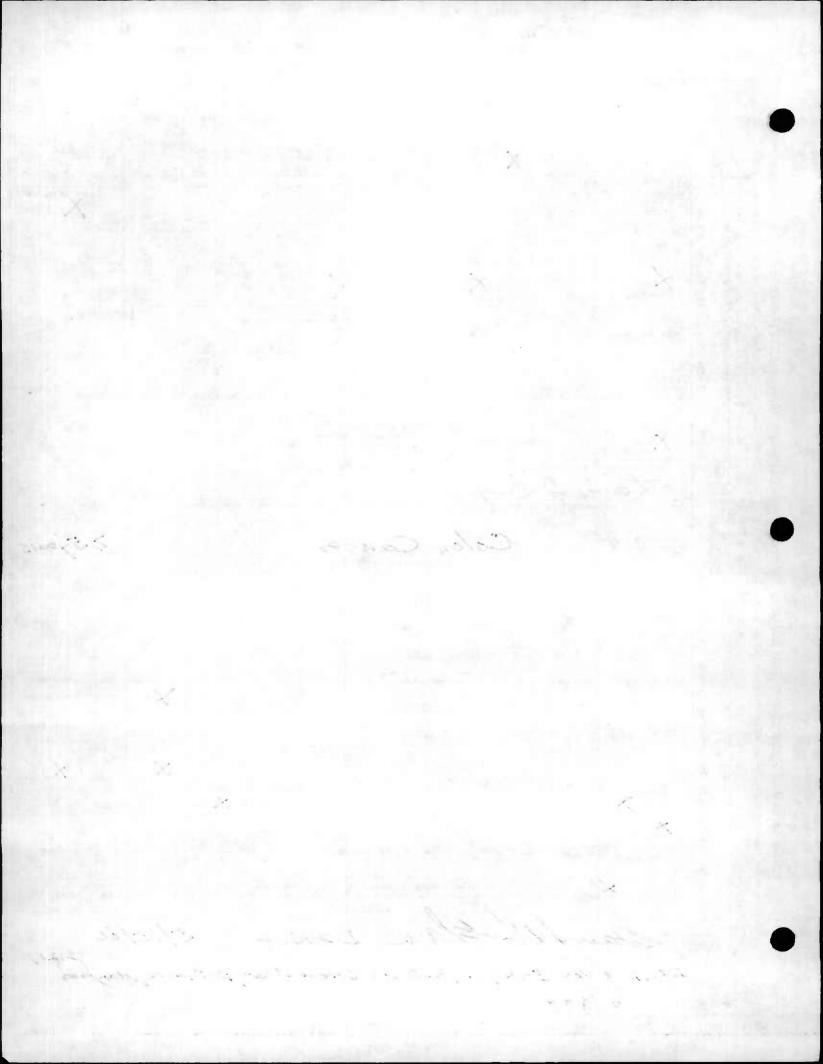
30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

Green Street Battomore Man

86

21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15816

sician	MS: #23 PART I, I 1. Decedant's Name (First, Middla,		2. Date of Das Month		Year	3. Time of Death					
/sician ledical	Alexander		nce				MAY	Dey 11, 20	OOO	1728 PM	
miner	4e Facility Neme (If not institution, 703. N. MADEI		r)			4b. City, Town, or I BALTIMO		4c. County	of Death		
1 r	219-46-3955	Sex 7. A	Age (In yrs. Ia 51	st birthday) If Ur Yrs. Mont	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 05-05		9. Birthpl Count	ace (Stete or Foreign try) VA	
	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location		-1			10	Od. fnsida City Limits	
ctor	MD NA	A	Bal	timore			1 ☑ Yes				
Funeral Director	10e. Street and Number 703 N. Made	ira Stre	Street 101. Zip Code 21205					USA	en of What Country?		
2	11. Marital Status 1 Nevar Merried 2 Marrier X X 3 Widowed 4 Divorced		Yes 2 □ No s, Give 1 □ Yes 2 X □			dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	Specify			
	15. Decedent's (Specify only highest	Education		16a. Decedent's U	Jsual Occup	pation during most of wor	rkina	16b. Kind of B			
-	Elemantary/Secondary (0-12)	College (1-4o	life DO NOT USE o			d)		Compa	n 17		
	17. Father's Name (First, Middle, La			Cal	vasii	18. Mother's Nar	ne (First, Middle,			Les tepads	
any Injury or other traumatic event, the Medical pace. To Be Completed	U	Willie	Mae	Spenc	е						
	19a. Informant's Name/Relationshi	(Type, Print)					Code) 21218				
	Delcina Spe	nce				11 Stre	et Bal				
	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Spe		e Gar	ce of Disposition (metary, cremetory crison I	(Neme of or other plea Fores	t VA Ce	Data em. 05-	20c. Location -			
	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility WM.C.March FH 1101 E.North Avenue										
edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to (or a	as a consequence as e consequence as e consequence	of):	OXICATION					
		d		313					1		
1	Part II. Other significant conditions HYPERTENSIVE A		23b. Did tobacco use contribu			the cause of death					
	HITEKIENSIVE A	THEROSCLER	OTIC	ARDIOVAS	COLAR	DISEASE	24a. Was	an autopsy med?	24b. Wa	are autopsy findings aliable prior to appletion of cause	
T						000	Yes 2 No		daath? Yas 2□ No		
S C	25. Wes case referred to medical				-	26. Place of Da	ath (Chack only o		7		
edical Certification: To Be (axaminer? XXXYes 2□ No	Hospital: 1 fnpa	tient 2 E	R/Outpatient 3	DOA Oth	nar: 4 Nursing H	lome XXRasid	dence 8 🗆 Oth	er (Specify)	
	27. Mannar of Death 1 □ Natural 5 ☑ Pending	28a. Date of In	ijury De <i>y Year)</i>	28b. Tima of P	28c. Injui			now injury occur	50.	BJECT	
	Pending investigation of Science of Holland Suicide of Homicide of						INGESTED DRUGS AND ALCOHOL 28f. Location (Street and Number of Pural Route Number. City or Town, State) 703 N. MADEIRA BALTIMORE, MARYLAND				
3	(Check only 2CXMedical Ex	Physician: To the best aminer: On the basis	of examination	edga, death occur	red at tha ti		and due to the	cause(s) and m	anner as st	ated.	
_	29b. Signeture end title of certifier	and mannar	statad.		29c. Licens	se number		29d. Date signe	d (Month, I	Day, Year)	
Med	The same and the same and same	1 //2			133						
Med) J.M. It OOME MAY 12, 20										
Medical Cert	30. Neme end address of person w	no completed cause of MS, M.D.	1000			, Baltim					

the property of the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Dev Month Year **Physician** John Anthony Sansone 2000 08:20 AM MAY 14, /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore Towson Saint Joseph Medical Center Hours Min. Jan. 5, 1922 If Under 1 Year 9. Birthplece (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 18 M 2□ F 78 217-18-9407 Yrs Director Usuei Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Departmant of Health end Mental Hyglene.
Important: if Hem 27 is marked other than "natural", or frems 23s or 28s-1 show any fujury or other traumatic avant, the Hedgal Exercise, must be notified at once. 1 Yes 2 No Baltimore Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9113 Ramblebrook Road 21236 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Meritel Stetus 1 ☐ Navar Married 2 X Merried Specity: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Anthony Sansone Mary Josephine Sansone 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9113 Ramblebrook Rd., Baltimore, MD 21236 Mrs. Mary Jane Sansone (wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 5/17/00 Fullerton, Maryland St. Joseph Church Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Sarvice Licensee 22, Neme and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD eller Buon a. U 21236 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 4 DAYS ACUTE HEPATITIS Examiner Due to (or es a consequence of): Examiner CORONARY ARTERY DISEASE physician and s the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the s should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown CONGESTIVE HEART FAILURE Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy cata has page 2 a 1 ☐ Yes 2 No 2 NO 1 Yes certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 80 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mennar of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Cartifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number malla mio

State Registrar

DHMH 16 Rev 6/95

30. Name end-addless of person who completed cause of death (Item 23a) (Type, Print)

MEHTA.

2000

JOGINDER P.

31. Date filed (Month Day, Year)

M. D. ,

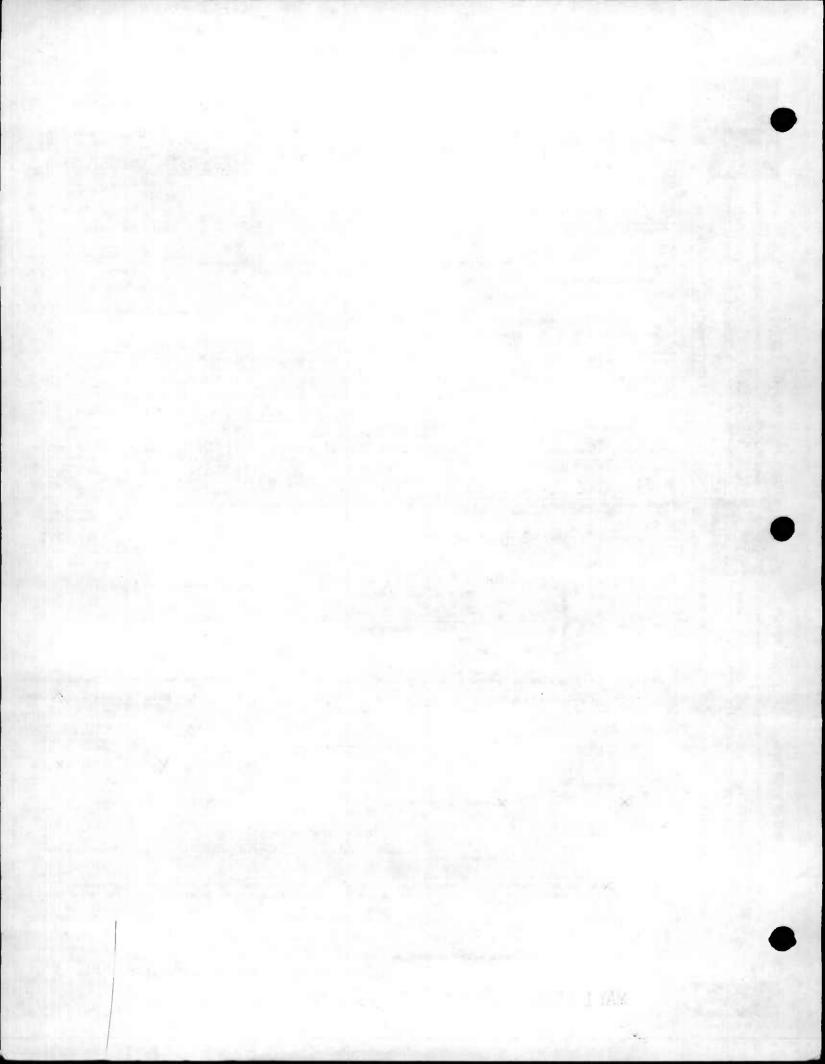
32. Registrar's Signature

Zener

D 41410

7601 OSLER DRIVE, TOWSON, MARYLAND 21204

2 one



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mar Daniel Lewis Smedley 9:00 PM 13 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore Square 6. Sex 7. As (In yrs. la Kosedale H Under 24 Hrs. 8. Date of Birth Hours Min. April 29, 1931 Maryland Maryland If Under 1 Year 5. Social Security Number (In yrs. last birthday) **Funeral** Days 1 M M 2 □ F 69 214-26-9403 Director Usuet Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Baltimore 1 Yes 2 No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ծ 21236 3 Cameron Court, Apt. G U.S.A. 'neturel', or items 23s 12. Was Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 Z,No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status is and 2 should be filed within 72 hours after. Heelth and Mental Hygiane. It is marked other than "naturel", or he other treumstic avant, the Medical Essential. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Automotive Sales Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Virginia Fitzpatrick James Lewis Smedley permit. Pages 1 and 2 sh Department of Heeith and Important: If Item 27 is m any injury or other treum page. 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3 Cameron Ct., Apt.G, Baltimore, MD Mrs. Jayne J. Smedley (wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 5/17/00 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, 21. Signature of Funeral Service Licensee Beron a Mellen 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical 45 Minutes Examiner Due to (or es a consequence of): Physician/Medical Examiner Artery vronary. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician s the burial Hear 68760 Valvular Due to (or as a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 NO 1 Yes 2 No certificata of Vital or Attending Physicien: funaral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Division Hospital or Attending in 24 hours effer death.

He Funeral Director: After pletely filled in by the fur To the within 2.
To the F

State

DHMH 16 Rev 6/95

Registrar

Medical

31. Date filed (Month, Day, Year) MAY 1

3 Suicide

29e. Cartifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

9000 Franklin Square Drive Baltimore, Maryland 21737 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

oaks

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year) 13

2000

13th, 200 Maryland

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mine	er		on Specia	-		1			4b. City, Town, or Balti			of Deeth	.h	
		5. Social Security 216–42–	y Number (3. Sex 1 ★ 2 □	7. Age	(In yrs. lest		Undar 1 Year onths Deys	If Under 24 Hrs	8. Dete of Bi			plece (State or Foreigntry) MD.	
	-	Usuel Residence	ot Decedent 10b. County			10a City T	own or Location						10d. Inside City Limit	
ŏ		MD.	ANNE A	RUNDEI.			APOLIS	и					1 XYes 2 N	
DIECTO	-	10e. Street and N				112121		Of. Zip Code	-		10g. Citizen of	Whet Cou	ntry?	
T IR	L		GE CREEK				40.14/	2140		Casait. Vac an N	USA	an Ameri	can Indien,	
Dy rui	1		37			2. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		 Wes Decedent of Hispenic Origin? (S It Yes, specify Cuben, Mexican, Puert Yes 2 X No Specify: 			Ble	ck, White, y: BLA	etc.	
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			Name/Reletionshi						ot end Number or F				Code)	
	-	20a. Method of E				20b. Place ceme	of Disposition	n (Neme of		Dete	20c. Location		own, State	
		4 Donatio	n 5 ☐ Other (Spe	ecify)	Om State	ANNAP						_	MARYLAND	
		21. Signature of	Funeral Service Li	eese		9				M. REESE & SONS MORTUARY POLIS, MARYLAND 21401				
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Johnson II was

MAY 1 7 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year TARRY 1045 AM LOUISE MAY 15 2000 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Hospital Prince George's Regional Laurel Laurel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number Months Deys 1 M 2 F 228-50-9654 73 02-25-27 Usual Residence of Decedent 10d. tnside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Vance Henderson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 459 Morgan Road 27536 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) 12th Grade 2yrs. Homemaker in own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Small Elizabeth John Henry Small 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 17104 Brookmeadow Lane Upper Marlbor Wilma Tarry 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State Antioch U.C.C. Cem. 05-20-2000 Townsville, NC 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lie 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue alions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, cause on each line. 23a. Part1. Enter the disease, or o shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Asth Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Onknown Obesit 24b. Were autopsy findings eveileble prior fo completion of ceuse of deeth? 24e. Wes en autopsy performed? 1 ☐ Yes 1 Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 2se. 1 any injury or other traumatic event, its marked other pages.

physician end s the buriel-trensit The law requires that the deeth certificate be executed ettending p signed by the e

Physician/Medical Examiner

by

Completed

Be

Certification: To

Medical

State

Registrar

peen page 2 : certificete or Attending Physician: director. After this funeral within 24 hours efter deeth.

To the Funeral Director: Af deeth. Hospital

Division of Vital Records, P.O. Box 68760

25. Was case referred to medical 1 Yes 2 No

3 Suicide 4 ☐ Homicide 29a. Certifier

(Check only one)

27. Manner of Death

2 Accident

1 Stratural

5 Pending Investigation

6 Could not be determined

Hospital: 1 Dopatienf 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Pleca of Injury - At home, farm, street, fectory, office bullding, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

S. SAINI

26. Place of Death (Check only one)

Lawel

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) * Csrtifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and manner stated.

29b. Signeture end title of cartifier ritan 5

29c. License number 028998 29d. Date signed (Month, Dey, Year)

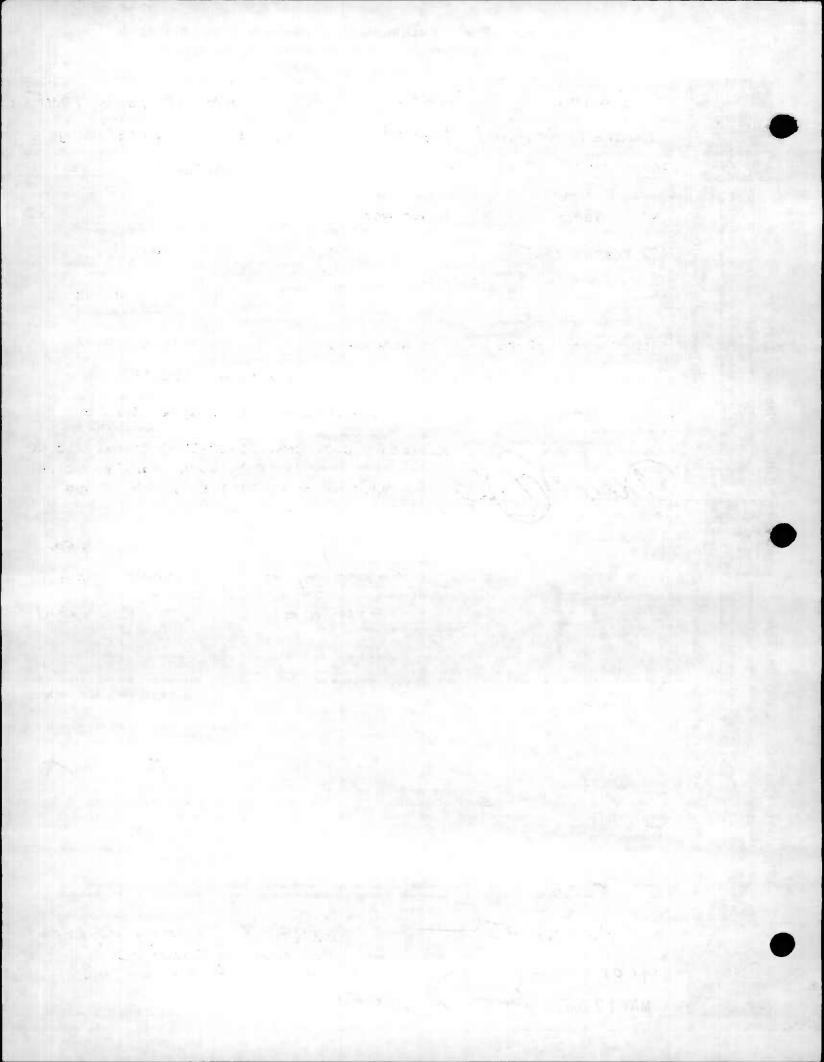
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 Cherry

PRITAM 211 Law Suite

31. Date filed (Month, Dey, Year)

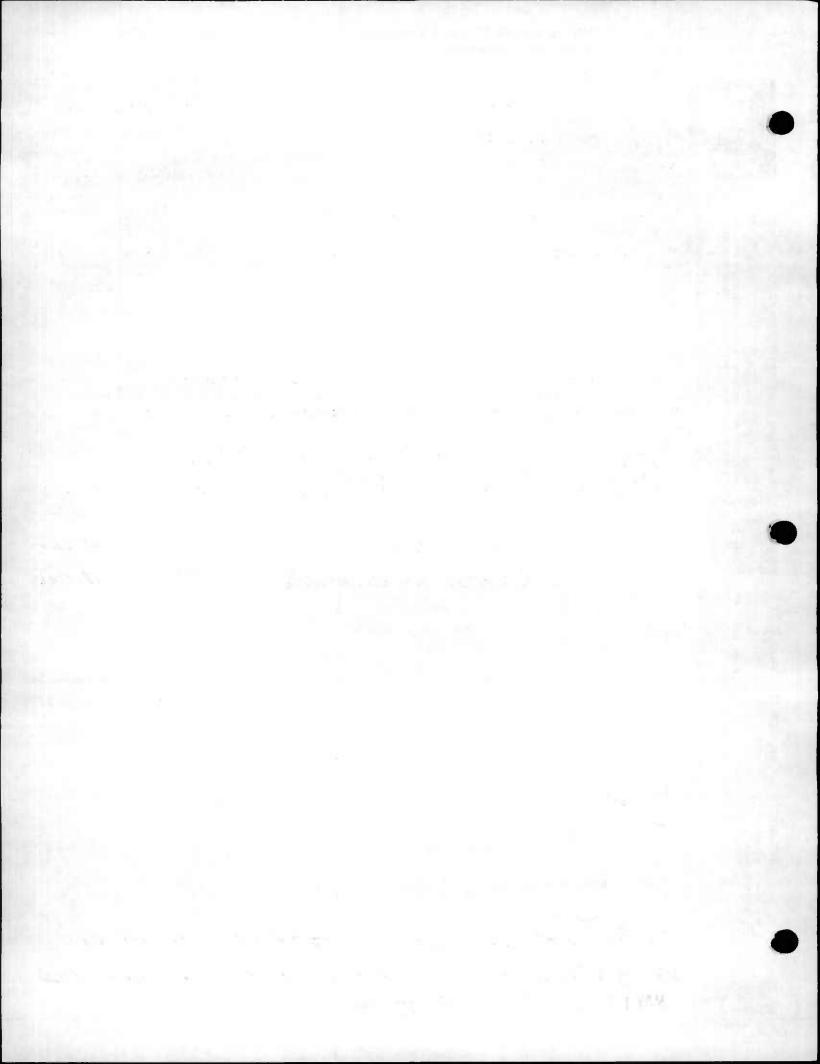
MAY 1 7 2000

Lane 32. Registrar's Signa ure



		Decedent's Nam	ne (First, Middle,	Last)					2. Date of D			3. Time of Dea
Physic /Medi			RICHA	RD LOU	IS T	OEBBE,	JR.		Month May	Day 15 20	Year 000	0440
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		708 Locust St.						Cambr	idge	Dor	ches	ster
Funeral		5. Social Security N	-9.07	. Sex 7 113 M 2□ F		. last birthday) Yrs.	If Under 1 Year Months Days		. (Month, D			lace (Stete or For
Director		538-32-4 Usual Residence			63	113.			Dec 2	2, 1936	Kent	ucky
show		10a. State	10b. County		10c. Ci	ity, Town or Loca	ation	1				Od. Inside City Lin
s 23a or 28a-f sho nust be notified a	cto	Maryland	Dorch	ester	(Cambridg	ge					1 ☐ Yes 2€
or 28	Oire	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of V	What Coun	try?
238	ral	708 Locu	st Stree					21613			Α.	
Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director			r Married Married		2. Was Decedent Ever in U,S. Armed Forces? 1. Yes 2 No If Yes, Give Year or Dates:		S. 13. Was Decedent of Hispenic Orlgin? If Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 ☒ No Specify:			o- 14. Race Blace Specify	e - America ck, White, c Whi	etc.
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ked c	To Be	Richard	L. Toebb	e					France		/	
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27 to		Mary Pra	tt Toebb	e / wife		708 Lo	ocust St	reet Cam	bridge,	Marylan	d 21	613
or oth	}	20a. Method of Dis 1 -Burial 2		☐Removal from Si		Place of Disposi cemetery, creme	ition (Neme of etory or other ple	ace)	Date	20c. Location -	City or To	wn, State
tant:		4 Donation	5 ☐ Other (Spe	cify)	1			metery	5/18/200	00 Baltin	nore,	Maryla
Dapa Impor		21. Signature of Fi	uneral Service Lic	C D		I		ess of Facility Funeral kens Ave			Mary	land 21
cian and cian and cian and market ansit and market and		disease or condition resulting in death)	711	101		11-1-	01.12	. 0			1	1 100
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Florine H. Thomas 6:30 Pm Mal 12 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Levindale Geriatric Center Baltimore n/a If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√X Months Days Hours 213-14-5813 80 Director Oct. 3, 1919 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits ?? is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Baltimore Md. n/a 1XXes 2 □ No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2315 Koko Lane 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11 Marital Status Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: Black Be Completed by 3√Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City nentary/Secondary (0-12) College (1-4or 5+) Public Schools 12th Grade Secretary Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental William Hutchins Vertie Branson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau 2303 Poplar Grove Street Baltimore, Md. 21216

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Physician /Medical Examiner

inquires that the death certificete be executed

Box 68760.

P.O.

of Vital Records,

Division

The law

this

al or Attending P affer death. I Director: Affert of in by the funer Affer

filled in by

Florine

Baltimore.

Physician/Medical Examiner gned by the attending physician and be detached for use as the burial-transit

Reginald C. Thomas

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licen.

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 am 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Onset end Death Due to (or as 23b. Did tobacco use contribute to the cause of death?

Date

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown obstructive dung disease, Hypertension 24a. Wes en eutopsy performed? nent aspiration preumonias, Amenda Astre dissection, weisangtact injection 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifier

son

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by

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Certification: To

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certified

Kanganajan

May 2000

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 Yes 2 No

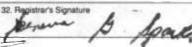
20c. Location - City or Town, State

May 18 Baltimore, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMASWAMY I RANGARAJAN . 7445A FURNACE BRANCH RD. GLEN BURNE 31. Date Hed (Month Day, Year) 2000

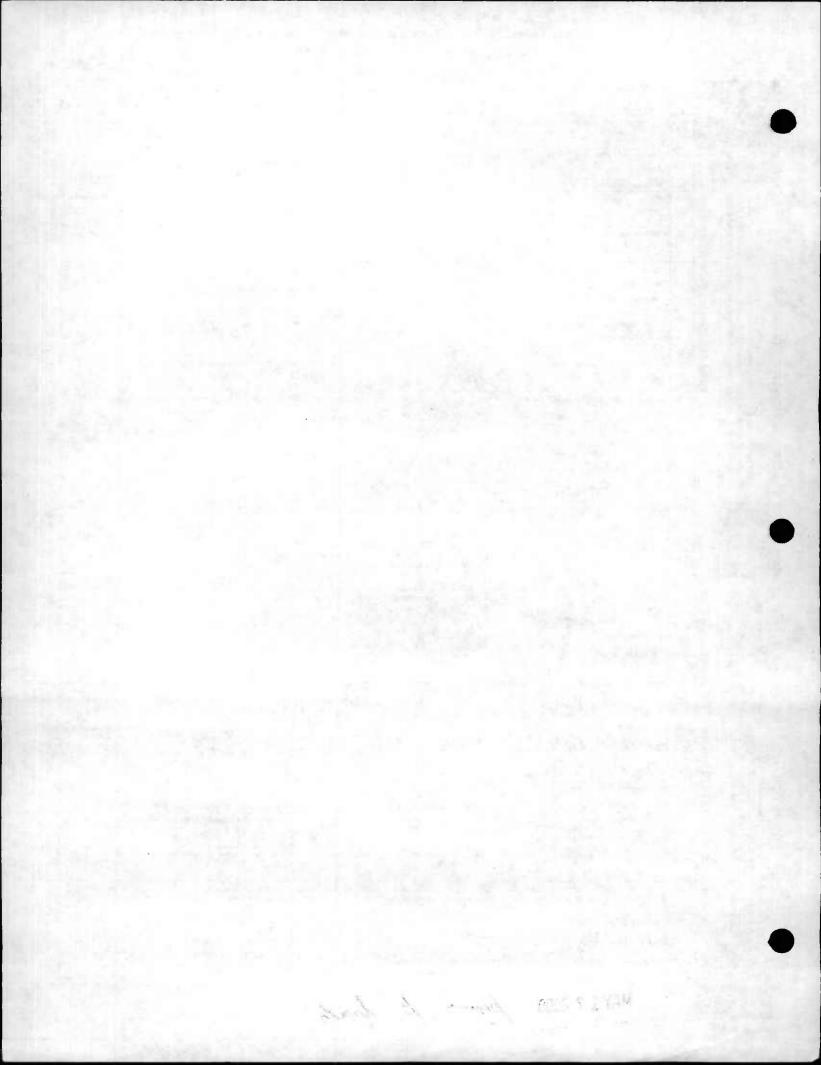
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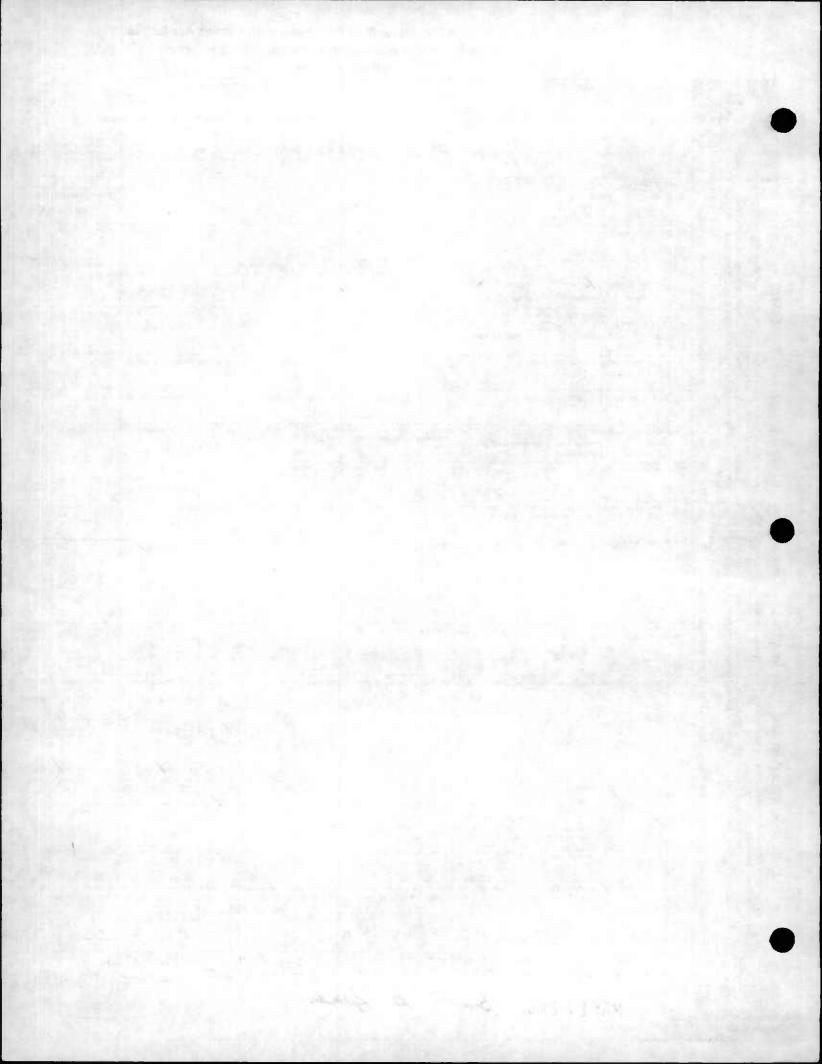
To the Hospital
within 24 hours a
To the Funeral D

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of L	Death	Reg. No.	15823					
	- ·	1. Decedent's Nama (First, Middla, Last)			2. Deta of Month	Deeth Day Year	3. Time of Death					
	Physician /Medical	Lula Ann		ridd	May	13, 2000	5;30 am					
\hat{k}	Examiner	4a Facility Nama (If not institution, giva s	treet and number)	4	b. City, Town, or Location of D	eath 4c. County of Dea	th					
		3478 Loganview	Dr.		Dundalk	Baltimo	ore					
	Funeral Director	5. Social Security Number 6. Sex 218-18-5646	N. OFF	hday) If Under 1 Yaar Months Days	If Undar 24 Hrs. 8. Data of (Month) Apr.		thplece (Stata or Foraign ountry)					
	tand	10a. Stata 10b. County	10c. Cily, Town	or Location	TANKET IT		10d. Insida City Limits					
	28a-f sh corried	MD. Baltimo	re Dunda			10- 022	1 ☐ Yes 2 No					
	iter deeth with the Maryland r hema 23a or 28a-f show inser must be notified at Funeral Director	10e. Street and Number 3478 Loganview	Dr.	10f. Zip Coda 21222		10g. Citizen of What Country? USA						
21215-0020	ours after rat", or he Francisco	11. Merital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever In U,S. Armed Forcas? 1 □ Yas 2 ■ No If Yas, Giva Yaar or Datas:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yas 2 No	spenic Origin? (Spacify Yas on, Maxican, Puarto Rican, atc.) Specify:							
5	ed within 72 ho ygiena. Ner than "neturn ft, the Modreal Completed	15. Decedant's Educ (Specify only highast grada	ation 16a. complated)	Decedent's Usual Occupa (Giva kind of work dona of lifa. DO NOT usa retired	ation turing most of working	16b. Kind of Businass	Vindustry					
121	within than than than than than than than tha	Eiamentary/Secondary (0-12)	Collega (1-4or 5+))							
	Hygie of the control	6 yrs. 17. Fathar's Nama (First, Middla, Last)	70	ner	18. Mother's Nama (First, Mic	Day Care	3					
⊆ .	2 should be filed within 72 hours 1 and Mental Hygiena. is marked other than 'netural', reumetic avent, the Medical Ex- TO Be Completed by	Frederick Geo	rge Herbert		Evelyn Viol							
	permit. Pagas 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netur any injury or other traumatic avent, the Medical ance. To Be Completed	19a. Informant's Name/Ralationship (Typ. Frederick Tidd	Husband 3	478 Loganv	iew Dr. Dun	dalk, Md. 2	21222					
Baltimore	Pagas 1 ant of He nt: If Iten ry or oth	20e. Method of Disposition 1 Buriel 2 □ Cramation 3 □ Re 4 □ Donation 5 □ Other (Specify)	camatan	Disposition (Nama of c, cramatory or other place as of Fait	h Cem. May 1	7 Rosedale						
Balti	permit. Page Department of Important: M eny injury or once.	21. Signature of Funeral Service License		Connelly	s of Fecility Funeral Home	e of Dundal	lk, P.A.					
		22a Part Enter the disease or complic	. Connecy		ers Point Re		Md 21222 Approximate					
· 19	Thusialan	23a. Part f. Entar tha disaasa or complic shock, or haart failura. List only on	a causa on aach lina.	ot aritar tha moda or dym	g, such as cardiac of raspilato	ry arrast,	Intervel Batween Onset end Deeth					
	Physician /Medical	Immediate Cause (Final		one week								
	Examiner	disease or condition rasulting in death) a.	Dehydration	s a consequence of):								
	in the last	The second	e three x									
	n and latransit Examine	Sequentially list conditions.	Dementia of		1016 3 17/16		in ce jours					
,09,	8 55 2	If any, leading to immediate cause. Entar Underlying Cause (Disease or injury c.										
Box 68760	n centilicate be unding physici use as the bu in/Medical	rasulting in death) Last	Dua Io (or as a co	onsequence of):	1100							
	deam of attended for us	Part II. Other eignificant conditions cont	ributing to death but not rasulting in	tha undariving causa give	en In Pert I. 23b.	Did tobacco use contribut	te to the cause of death?					
. P.O.	es that the deam or igned by the attend be detached for us by Physician/					1 - Yes 2 No 3 - F	Probably 4 Unknown					
Division of Vital Records,	been s should should				24a. \	Was an autopsy 24b. performed?	. Wara autopsy findings evailabla prior to complation of cause of death?					
ď	The ta					I□Yas 2XNo	1 □ Yas 2 No					
ta	certificate has rector, page 2 Be Comp	25. Was casa rafarred to medical	- No. of the last of		26. Place of Daath (Chack o	nly ona)						
>		examinar?	ospitel: 1 Inpatiant 2 ER/Out	patient 3 DOA Oth	er: 4 Nursing Home 5	Rasidanca 6 □Othar (Spe	ecify)					
o uo		27. Menner of Deeth 1 Natural 5 Panding 2 Accident Invastigation	28a. Data of Injury (Month, Day Year) 28b. T	jury Wor		ribe how injury occurred						
Divis	plas or Attending Pours after death. and Director: After Ittled in by the funeral lifed in by the funeral it Certification:	3 Suicide 6 Could not be datarmined	28a. Placa of Injury - Al homa, far building, atc. (Specify)	m, straal, factory, office		f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)						
	A hour Funera lical		cian: To the best of my knowledge, er: On the basis of examination end and mannar stated.									
-	Med	29b. Signatura and titla of cartifiar		29c. Licans	a number	29d. Dete signed (Mon						
	N	Michael Weste			2451	May 15, 2						
(De	30. Nama and address of person who cor Michael Wester	mpleted causa of daath (Item 23a) (man, M.D. Joh	Type, Print) us Hopkins	5505 Hopkins Geriatuics Cont	Barview Circ	de MD 21224					
	State Registrar	31. Dete filed (Month, Dey, Year) MAY 1 7 200	32. Registrer's Signetura	& Span								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** BEN D THOMPSON 0215 05 OB 00 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE VETERANS AFFAMS MEDICAL CENTER 5. Social Security Number 112-23-5469
Usual Rasidance of Dacedant 10h. Cou Sociel Security Number 6. Sex 1 M M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs, last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1925 Tennessee Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Funeral Director 10e. Street and Number 101, Zip Code 10g. Citizen of What Country? 6 21202 or Herna 23a death 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U.S.
Armed Forcas?
1 [YYas 2 □ No
If Yas, Giva
Yaar or Dalas: 14. Rece - American Indian 11. Marital Stetus Black, White, etc. filed within 72 hours after 1 Navar Married 2 Married Specify: B 1 Yes 2 No 21215-0020 ack Specify Completed by 3 Widowed 4 Divorced netural 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry tary Secondary (0-12) Il Hygiene. Collega (1-4or 5+) :00 k Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Peges 1 and 2 should be fill ment of Health end Mental Hillant: If itsm 27 is marked out Be Inomosor Informant's Name/Relationship (Type, Pnnt) permit. Peges 1 and 2 s Department of Health er Important: if itsm 27 is any injury or other trau 01202 20b. Placa of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata emetery5-16-00 Dwings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furierel Sarvice Licer Home P.A. Balto, MD. Fredhilton Pass 21229 filer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical ACUTE TRACHEAL Occusion 10 minutes Examiner Dua to (or as a consequence of): 5 days Physician/Medical Examiner TRACHEOSTOMY The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated events rasulting in daath) Last burial-tran Dua to (or as a consequence of): 20 years Box 68760. EMPHYSEMA Dua to (or as a consequence of): the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à director, page 2 should be 24b. Wara autopsy findings available prior to Be Completed 24a. Was en eutopsy certificate has been complation of causa of death? 1 Yas 2 No 2 No 1 Yas Attending Physician: 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No invastigation To the Hospital or Attendivitin 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accidant the 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Phyelcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. Medical 29a. Cartifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) MAY 1 7 2000

30. Nama and addrass of person w

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J. FRANCO MIN 32. Registrar's Signature

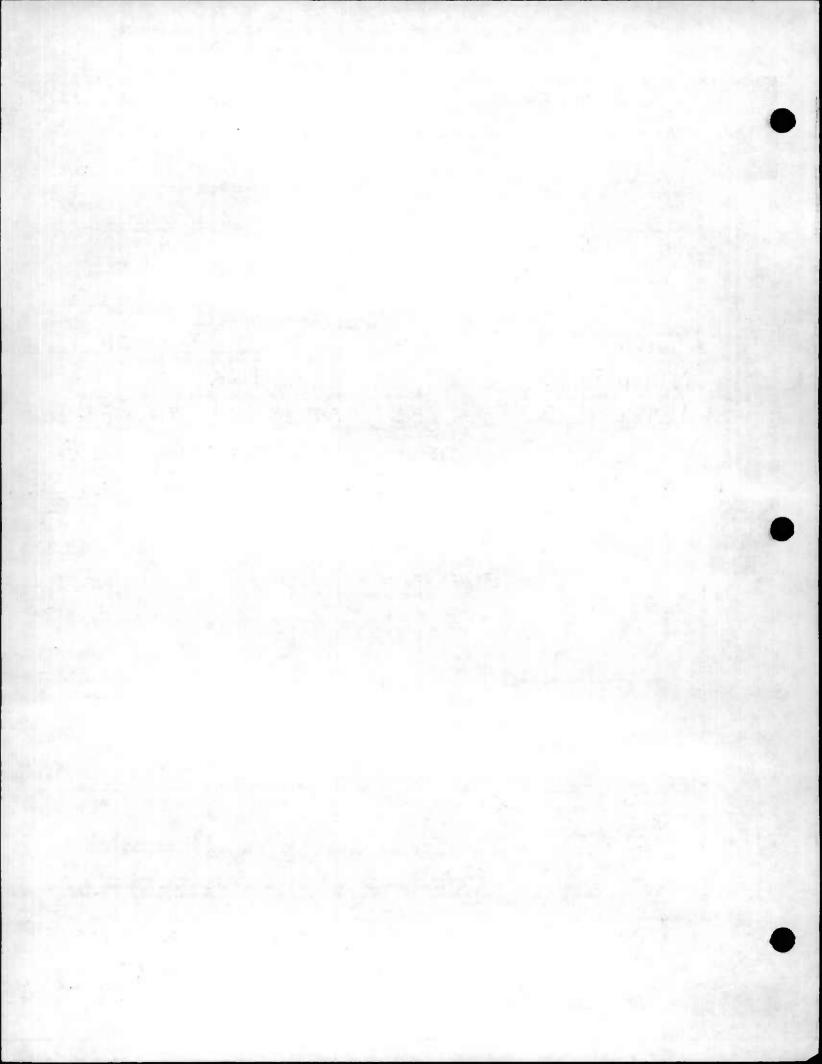
o complated causa of daath (Item 23a) (Type, Print)

ranco MD

porks

DETT OF MEDICINE N3ED9 UMMS 55. GREENEST
BALTIMONE, MD21201

05/08



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death M9744 **Physician** heila 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Beath 4c. County of Death Examiner NA MeRC Ba (timore HOSPITA ff Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sax If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Funeral Deys Months 1 M 2 F 46 MD 219-60-7608 Yrs. 10-26-1953 Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show man be notified at 1 Nes 2 No **Funeral Director** AC Ba Ctimores 10f. Zip Coda 10e. Street and Number 10g, Citizan of What Country? PRESTON 21202 5. items ; 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Peges 1 and 2 should be fited within 72 hours effect Department of Health and Mental Hyglens. Important: If fem 27 is marked other than "natural", or fee any injury or other traumatic event 1 Yas 2 1400 If Yas, Giva 1 Nevar Marriad 2 Married 1 Ves 2 PNo Specify: Specify: P Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0,12) College (1-4or 5+) ware house Work Labon N 17. Fathar's Neme (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) 1)a W. 1500 2 ler non ones 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) APT 328 Patterson (mother) Preston St. 50/2 Balto. Md. 21202 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Date 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Ramoval from Stata ands down Cem -LION 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Fecility tuneral 10200 Ba (6) Street Md 21213 Caroline 1129 N. 23a. Part / Enter the disaess, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** weeks /Medical encephalopothy Immediata Causa (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or es e consequence of): Dua to (or as e consequence of): for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? mmunodeficiena 1 Yes 2 No 3 Probably 4 Unknown Syndrome by 24b. Wara eutopsy findings evallable prior to complation of cause of death? 24a. Wes an autopsy performad? Completed 1 Yas 1 Yas 25. Was casa rafarrad to medical axaminar? Be 26. Place of Death (Chack only one) Hospifel: ↑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No edical Certification: To this 28a. Data of Injury (Month, Day Year) 27. Mengar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Natural
2 Accident 5 Pending invastigation To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. 1 Yes 2 No 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

The lew requires that the death certificate be executed Records, P.O. Division of Vital or Attending Physician:

Box 68760,

with the Meryland

Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

30. Name and addrass of person who ca

29a. Cartifiar (Check only one)

29b. Signatura and fitla of certifier

mpleted cause of death (Itam 23a) (Type, Print) 30/1 000

122 Registrar's Signate

29c. Licensa number

29d. Date signad (Month, Day, Year)

Paul Place Balhniere MD 21202

ORIGINAL

32. Ragistrar's Signature

parts

31. Data filed (Month, Day, Year)

Registrar

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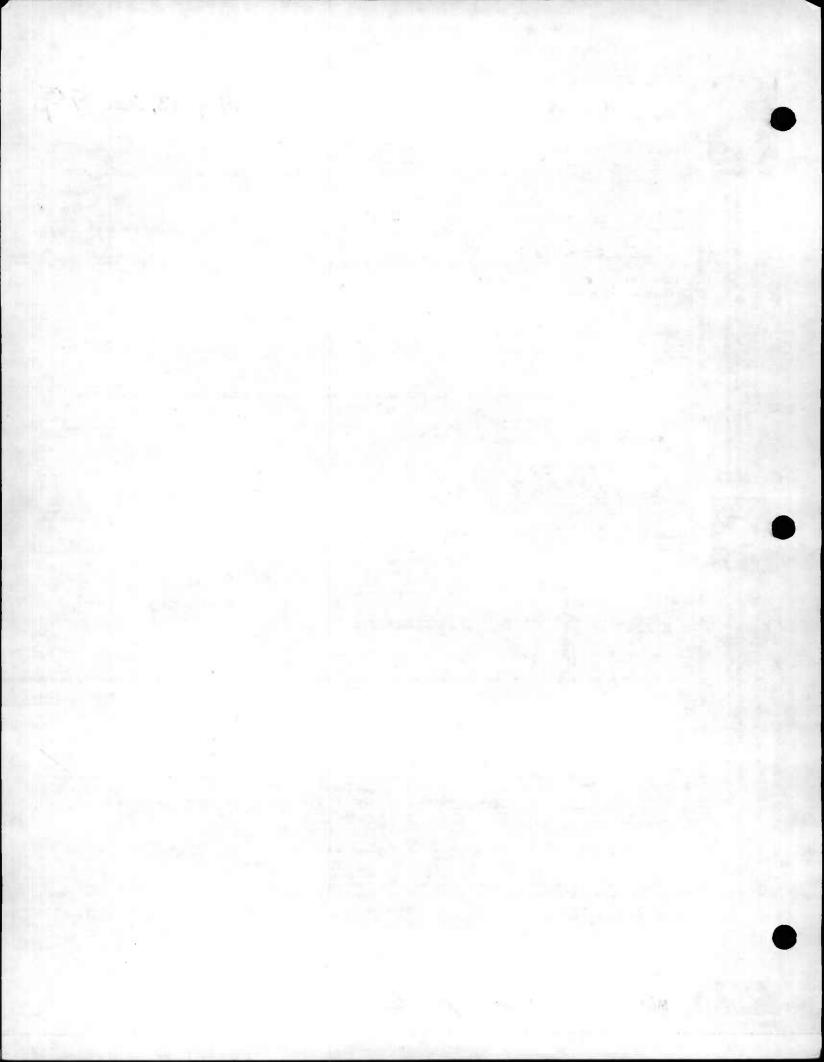
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 5 8 2 7 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Year **Physician** 2000 Norman Lee White /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date Mercy Hospital Hospice N/A5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 MM 2□ F Months Days Hours Yrs. Director 215-66-0578 46 April 4, 1954 Maryland Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show 1 ☐ Yes 2 No Directo Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 23. 7810 Clark Road 20794 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No II Yes, Give Year or Dates: natural, or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondery (0-12) 12 College (1-4or 5+) Mechanic Sturon Spring Co. permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: If them 27 is marked oth any Injury or other traumatic event and injury or other traumatic event ances. 17. Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward J. White Sr. Mamie Eva Crow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. White 7810 Clark Road Jessup, Maryland 20794 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-18-00 Brooklyn Park, Maryland Cedar Hill Cemetery 21. Signature of Fungral Service License 22. Name and Address of Fecility McCully-Polyniak Funeral Home PA 130 East Fort Avenue, Baltimore, Maryland 21230 Approximate Interval Between Onset and Death 231 Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Rectal Care Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence ol): Physician/Medical Examiner The lew requires that the death certificate be executed nding physician end use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Due to (or as a consequenca of): P.O. 1 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. É 24b. Were autopsy lindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital Hospital or Attending Physician: '24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director; I 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Yes 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, State) pletely filled in by 4 Homicide Medical 29a. Certifier Certifying Physician: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the 29b. Signatuse and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40854 00 M 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Bultimore, St Pas MD Ruseberge 21202 MO 301 31. Date liled (Month, Dey, Year) 32. Registrar's Signature Registrar 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Year **Physician** WARREN 03:36 JOHN MAL 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BALTIMORE BALITIMORE ST . AGNES HEALTHCARE If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Min. | May 3, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) 6. Sex **Funeral** Months 1X M 20 F Yrs. Director 213-18-6669 81 Maryland Usual Rasidence of Decedent 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits "natural", or Nems 23s or 28s-f shored call Examiner must be notified at Maryland Baltimore Catonsville 1 ☐ Yas 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane 21228 HR 103 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ☑ No
If Yas, Giva
Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian Black, Whita, atc. 1 Nevar Married 2 Married White 1 Yes 2 No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Consultant Engineer . Pages 1 and 2 should be filled w Iment of Health and Mental Hygier lant: if Nem 27 is marked other th jury or other traumatic event, the Mechanical 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surnama) Be Alexander Woronovich Irene Balia 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Doris E. Warren / wife 719 Maiden Choice Lane, HR 103, Catonsville, MD 21228 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Pages Department of Important: If It any Injury or o 1X Burjal 2 Cremation 3 Removal from State 4 Denetion 5 Othar (Specify) Holy Trinity Russ. Orth. 5/19/2000 Elkridge, Maryland ation Service Light 21. Signature 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical MYOCARDIAL INFARCTION Examiner Due to (or as e consequence of): Physician/Medical Examiner CORONARY ARTERY DISEASE physician and st the bunal-trans Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disease or Injury Dua to (or as a consequence of): that initiated events rasulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yee 2 No 3 Probably 4 Vunknown P cate has been sig page 2 should b 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 Yas 20 No this cartificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this cartifice Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Hospital: 1 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accidant 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effar To the Funeral Direcompletely filled in b 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signatura and titla of certifier

law requires that the death certificate be axecuted

Box 68760.

sion of Vital

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filed within 72 hours efter deeth with the Maryland

3altimore, Maryland 21215-0020

Registrar

M.D.

29c, License number

1 1359

29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

MAY

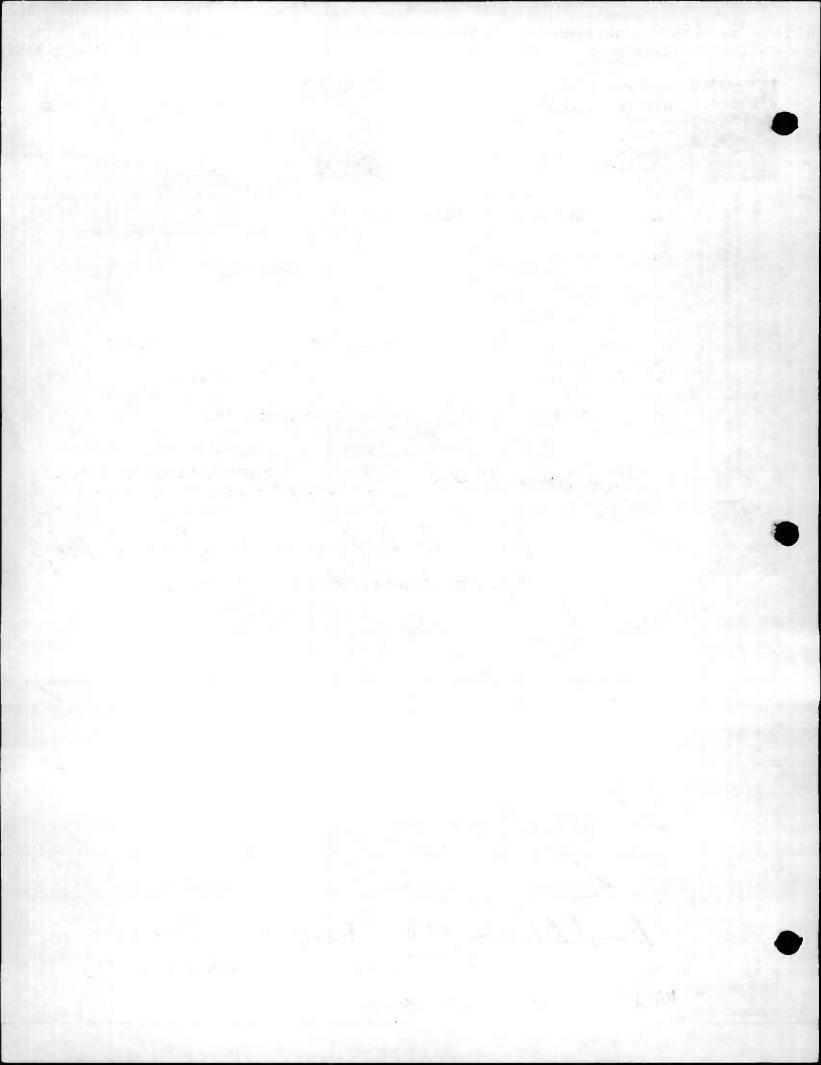
ST . AGNES HEALTHCARE, 900 CATON AVE, BALTIMORE, MU 21229 ABENA ADDO

MAY 1 7 2000 Data filed (Month, Day, Year) 32. Registrar's Signatura

State of	Maryland /	Department	of Health	and N	Mental	Hygiene
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2 3		Usual Residence of Dece 10a. State 10b	edent . County		10	City Tay	Iti						
anyla	=		,	-1/07-			n or Locetion	_				10	Od. Inside City Limits
8 A	Director	MD.	BALT	IMORE		RANDA	LLSTOWN						1 ☐ Yes 2 🔀 No
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DHMH 16 Rev 6/95



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Nancy	Winstead

State of Maryland / Department of Health and Mental Hygienes

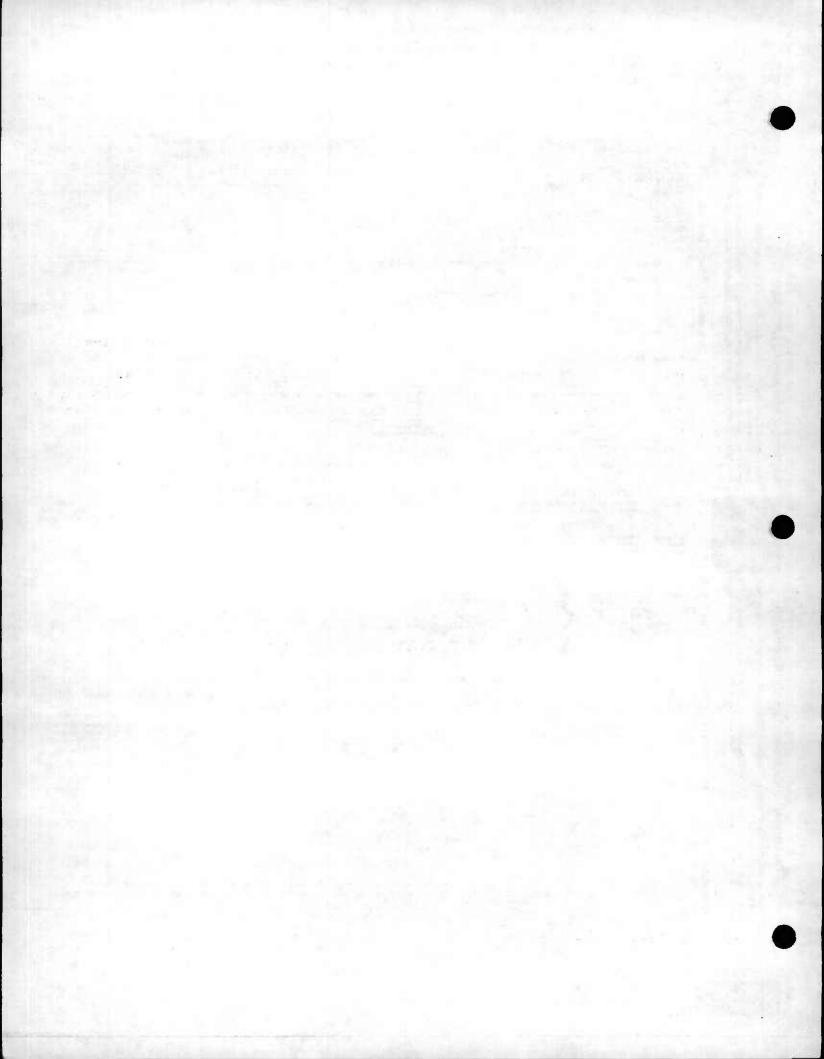
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	Nancy L. Wir	stead					Month May	Dey 11 2	Yeer 2000	10:09 A.M.			
/Medical - Examiner	4a Facility Nama (If not institution, giv				4b	. City, Town, or	Location of Death	4c. County		10.00			
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and and	19a. Informant's Name/Relationship (Stephen D. Wi	Type, Print) Husba	and 19b. Meilir	ng Address (S	treet a	nd Number or Au	iral Routa Number	City or Town,	Stata, Zip	21200			
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buria al	Causa (Disease or injury	c											
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signed d be del							24e. Was e	n autonou	24h Ws	ara sutopsy findings			
entificate has been si ector, page 2 should Be Completed							perform	nad?	COI	eilabla prior fo mplation of ceusa			
mple							,		of	death?			
Page Con							1 X Y	as 2 No	X	Yes 2□ No			
certificete rector, pag	25. Was cesa rafarred to medicat axaminar?					26. Plece of De	eth (Check only on	e)					
	1 X Yes 2 □ No	Hospital: 1 Inpatianf	2 NER/Outpatier	at 3 DOA	Othai	r: 4 Nursing H	loma 5□ Rasida	ince 8 DOth	er (Specify	y)			
dire	27. Mennar of Death	28a. Data of Injury (Month, Day)	(ear) 28b. Tima of	28c	Injury	at ?	28d. Dascribe ho	w Injury occur	red				
nerel dire	4 X Males and E Donadine		,,	М		as 2 No							
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Within 24 hours and open. To the Funeral Director: After this completely filled in by the funeral director Address of the funeral director and the funeral director for th	2 Accident 3 Suicide 4 Homloida 29a. Certifier (Check only one) 29b. Signatura and titla of certifier	ysician: To the best of niner: On the basis of a and mannar state	ny knowledga, deelt kamination and/or in d.	vastigation, in	my opi	inion, daath occu	urred at the time, d	ete and placa,	and dua to	Day, Year)			
within 24 hours afte To the Funeral Dire completely filled in Medical Cert	2 Accident 3 Suicide 4 Homloida 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of a and manner state	ny knowledga, deelt kamination and/or in d. th (Item 23e) (Type,	29c. L	my opi	number C.M.E.	urred at the time, d	ete and placa, 9d. Data signe May 12	and dua to	Day, Year)			

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 5 8 3 State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	, 0	eg. No.	
Dhualaia	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	h Day Yeer	3. Time of Death
Physiciai /Medica	FIODE I ADTICITEDE	MAY 3,		1:05 AM
Examine	4e Facility Neme (II not institution, give street and number) 4b. City, Town	, or Location of Death	4c. County of Deet	
		KVILLE	MONTGO	
Funeral Director	5. Social Security Number 154-09-4588 15 Age (In yrs. last birthday) 15 Yrs. 15 Usuel Residence of Decedent	Hrs. 8. Date of Birth Min. (Month, Dey Sept 28	, 1914 Nev	thpiece (Stete or Foreign ountry) W Jersey
pung and	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
uth with the Manya 23a or 28a-f shor ust be notified at	Maryland Montgomery Montgomery Village			1 ☐ Yes 2 ∏ No
vim the Me or 28s-f	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Whet Co	ountry?
4 52 m			United Sta	ites
ler des	T	? (Specify Yes or No- uerto Rican, etc.)	14. Rece - Ame Bleck, Whit	
	Year or Detes: 10/45		Specify:	white
	(Specify only highest grade completed) (Give kind of work done during most of	working	16b. Kind of Business/	Industry
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Maryland 4 2 should be flu 1 and Mental Hy 1 smarked oth Traumatic event	7	ılia	Russo	
ary ment ment	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number of		City or Town, Stete.	Zip Code) 20886
M Page	Mary M. Artigliere, Wife 18227 Lost Knife Cir		-	
other and	20e. Method of Disposition 20b. Place of Disposition (Name of	Dete	20c. Location - City or	
altimore mit. Pages 1 partment of Hs portant: if iten y injury or oth	1 Burial 2 ACremetion 3 Removel from State 4 Dogration 5 Other (Sp. 5) Metropolitan Crematory	May 4,	Alexandria	Virginia
anth Sorte	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility		Funeral Ho	
00 88158	Say The 10 E. Deer Park I	rive, Gait	hersburg,	MD 20877
	23a. Pert 1. Enter the duesse, or complications that caused the death. Do not enter the mode of dying, such as carshock, or heart failure. List only one cause on each line.	rdiac or respiretory err	est,	Approximete Intervel Between
Physician /Medical Examiner	Immediate Cause (Finel disease or condition A ORTO ENTERIC FISTULA)			Onset end Death 4 weeks
I SLESHIES	Due to (or es e consequençe of):			4 1
B # 5	ABROMINA ABSCESS			Tweeks
and al-trar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
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- 5 0 4	CHIVANIE ASSETABLETIVE IN	/ MONARY	DISTASE	
Boath cer attendin of for use	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	l non Didea	hann an annidadh	to the cause of death 2
ds, P.O. BOX ires that the death cer signed by the attendir d be detached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23B. Did to		to the cause of death? robably 4 ☐ Unknown
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I RECORDS, P.O. The law requires that the state has been signed by the page 2 should be detected.	GASTROINTENTINAL BLEEDING	24a. Wes e		Were eutopsy findings eveilable prior to
The law require the law require the law require the law require the law requirements the law	GASINCO INTENTINAC ISCEEDING	perform		completion of cause of deeth?
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Altal	25. Wes case referred to medical 26. Place of	Deeth (Check only or		
hysici his cer al direc	examiner? 1 Yes 2 No Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi		ence 6 Other (Spe	icify)
ding Ph oding Ph :: After thi e funeral	27. Manner of Death 1 Netural 5 Pending (Month, Day Year) 28b. Time of Injury et Work? 2 Accident investigation 28c. Injury et Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred	
Division of Vital Reco To the Hoeptal or Attending Physician: The law re within 24 hours after death. To the Funeral Director: After this certificate has bee completely filled in by the funeral director, page 2 sho	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Si City or Town	reet end Number or Ri n, Stete)	urel Route Number,
he Hospitu in 24 houn he Funera pietely fille	29e. Certifier (Check only one) 12 Certifying Physician: To the basis of examinetion end/or investigation, in my opinion, deeth one end manner steled.	place, end due to the coccurred et the time, d	ause(s) end menner e ate end pleca, end due	s stated. e to the cause(s)
outhin Somple	29b. Signature and title of certifier 29c. License number	9d. Dete signed (Mont	th, Day, Year)	
1041	Doo3371	9 1	MAY 3 5	2.000
10+1	30. Name and address of person who completed cause of death (Item 23a) (Type Print)	1.	11/ 2/2	
	PAULT. WELFBINSKI, MD 18550 OFFICE PARK DR.	Gnithers	burg MD	20886
State Registrar	31. Dete filed (Manth, Day, Year) MAY 05 2000 32. Registrar's Signeture			



Physician /Medica **Examine**

Funeral Director

Anthony James

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Marylar Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Magical Examiner must be notified as

Baltimore, Maryland 21215-0020

1. Decedent's Name (Fire	t Middle I	ectl		(Certi	ficate o	of E	eath		2. Dete of D	Reg. N	ů.		3. Time of	Death
										Month	D		Yeer	-1113.501	
Anthony Jar 4a Facility Name (If not it			mharl				41	City To	wn. or I	Apri.		c. County	000	07:56	A.M
		at Hun		rive				Ga	mbr.	ills		Anne		ndel	
5. Social Security Number 212–15–7442		Sex 1⊠M 2□F	7. Age (In yrs	4 Y	N	If Under 1 Y Months Da	ear lys	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I Aug.]	Dey, Year		9. Birth Cou Illi	place (State ontry) nois	r Foreign
Usual Residenca of Dece 10a. State 10b. Maryland An	County	ında1		ity, Town		tion								10d. Inside C	
10e. Street and Number	ie Al	under) A	шарс		10f. Zip Co	de				10g. C	itizen of V	Whet Cou	ntry?	
1315 Colon	y Driv	ve				2140						ted S	State	es .	
11. Merital Stetus 1 Never Married 3 Widowed 4 1		Armed F	2⊠No ive	J,S.		s Decedent es, specify			gin? (S _i n, Puerte	pecify Yes or for Rican, etc.)	No-		ck, White,		
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Elementery/Secondery	(0-12)	College (1-4or 5+)			noruse re revent			ecia	list	R	etai]			
William J. 19a. Informant's Name/F William Jame/F	Arnone	(Type, Print)	ther		-		reet e	Const	tanc er or Ru	e Spar ral Route Num	ling ber, City	or Town,			
20a. Method of Disposition 1 ☐ Burial 2 ② Cre	n mation 3	☐Removal from	State 20b.	cemetery,	, cremat	ion (Name of tory or other atory	f place)		May 5,				own, State	'L
21. Signatura d'Euderai	Service Lie	nsee			22. N	lame and A	dres:	evy (y Ro	bert A e Inc 20814	. Pu	mphre	y Fu	ineral	Hom
23e. Part1. Enter the dis shock, or heart failu	ese, or cor re. List ont	mplications thet y one ceuse on												Approximat Intervel Bet Onset and	e ween
Immediate Cause (Final disease or condition resulting in death)		a. Cov	ntact	Gui			No	uno	(0'	f Hea	id		1		
		b							Ш						
Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or Injury		c		or as a co								4			
that initiated events resulting in deeth) Lest	l	I d	Due to (or es a co	nsequer	nce of):					G,			Jan Hi	
Part II. Other significant	conditions	contributing to d	leath but not re	sulting in t	the unde	erlying caus	e give	n in Pert I				11.4		to the cause	
										1	☐ Yes	2,25-No	3 Pro	obably 4 🗆	Unknow
										24e. We	es en eut dormed?	opsy	a	Vere autopsy vailable prior ompletion of of death?	0

Physician /Medical Examiner

Completed by Physician/Medical Examin After this certificate has been signed by the attending physician and funeral director, page 2 should be deteched for use as the bunat-trensit To the Hospital or Attending Physician: The lew within 24 hours after deeth.

To the Funeral Director: After this certificate has I Be Medicai Certification: To filled in by the

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1 Nes 2 No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6XXQther (Specify) Scene

1 X Yes 2 □ No 28a. Dete of injury (Month, Day Year) Found 4-29-00 28b. Time of Injury Processes AM 27. Manner of Deeth 1 Naturel 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

in

28c. Injury at Work? 1 ☐ Yes 2 Mo 28e. Placa of Injury - At home, term, street, fectory, office building, etc. (Specify) motor vehicle on road

28d. Describe how injury occurred licted gunshot 28f. Location (Street and Number or Rurel Route Number, City or Town, State) R + 450

1 PYes 2□ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. (Check only one) 29b. Signeture and title of certifier

29e. Certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

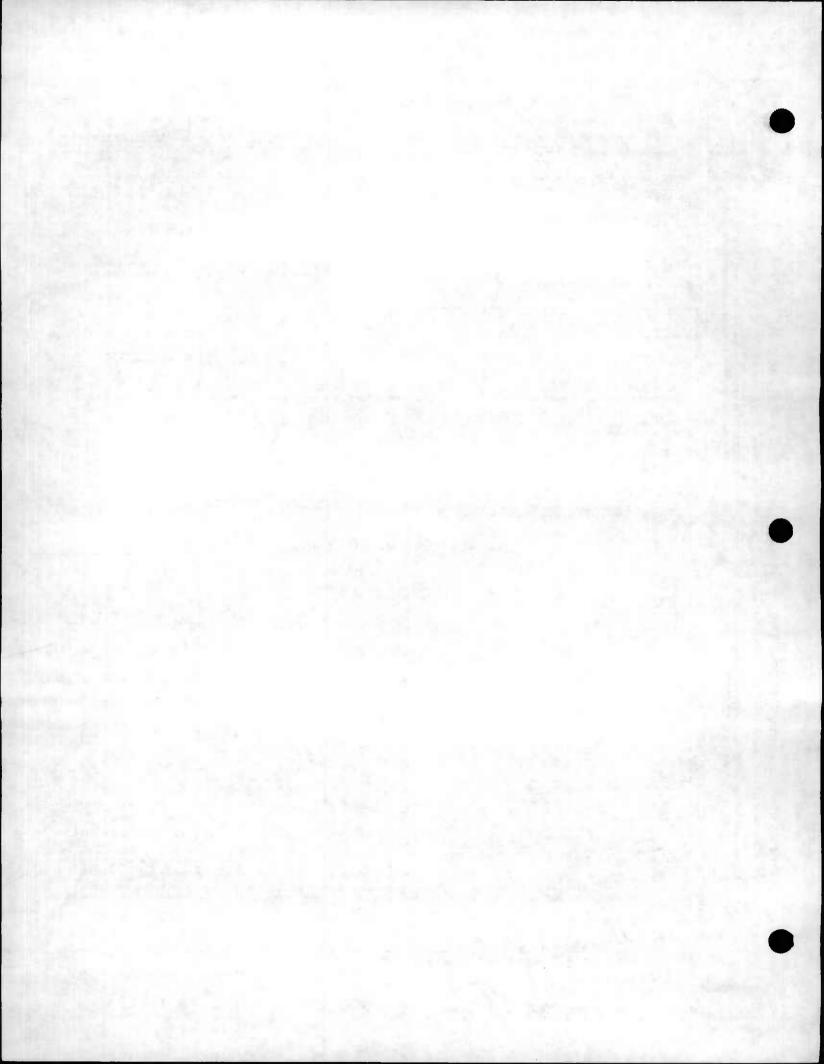
Jennis 31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

MAY 05 2000

32. Registrer's Signeture

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 800 AM oval 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard (00007 UK162515 (106/5/VC 5. Social Sacurity Number If Under 24 Hrs. If Undar 1 Year 8. Date of Birth (Month, Dey, 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) Days 192 M 2□ F Washington, D.C. 76 217-14- 7014 January 3,1924 Usuei Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Hyattsville XXYas 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3825 Hamilton Street # 102 20781 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give 145—1954 Year or Date 945—1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - Americen indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Private Industry Draftsman 6 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Clifford Raymond Allen Helen Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vaudell L. Allen/ Wife 3825 Hamilton Street# 102, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Locetion - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) May 2 2000 Cheasapeake Crematory, Inc. Beltsville, MD 21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Facility Columbia Mortuary Services, Inc. 20037 P.O. Box 58007 Washington, D.C. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Immadlete Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performad'

Physician /Medical Examiner

attending physician and for use es the burial-tren

datached

requires that the death certificete be axecuted

Records, P.O. Box 68760,

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

Saltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within Dapartmant of Health and Mantal Hygians Important: If flem 27 is marked other than any Injury or other traumatic avant

Physician/Medical Examiner

Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Aftar this certifics completely filled in by the funeral director, Be 2 Certification:

2 No 1 Yes 1 ☐ Yes 2 ☐ No

examiner?	rod to modical			26. Place of De	ath (Check only one)
1 Yes 2	No	Hospital: 1 ☐ inpatient 2	ER/Outpatient 3□ [OOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Deat 1 Neturei 2 ☐ Accident	5 Pending investigation		28b. Time of injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 4 Homicide	6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Numbar, City or Town, State)
29a. Certifier	Certifying Ph	vaician: To the best of my kno	wledge, death occurre	d at the time, dete end place	e, end due to the cause(s) and menner es stated.

29a. Certifier (Check only one) 1 Certifying Phyaician: To the best of my knowledge 2 Medicei Examiner: On the best of examination er end manner stated.	e, death occurred at the time, dete end place, end/or investigetion, in my opinion, death occurred	d due to the cause(s) and menner es stated. at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)

25. Was case referred to medical

31. Date filed (Month, Day, Year)

29c. License number

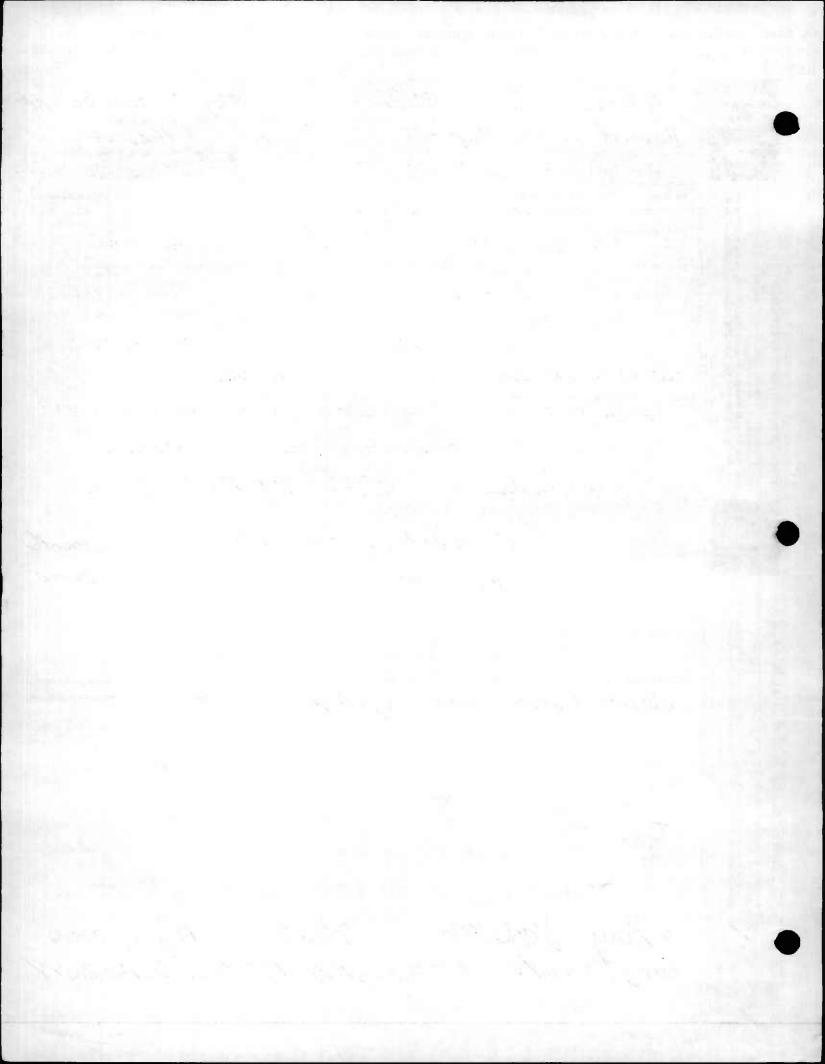
person who completed cause of deeth (item 23e) (Type, Print)

Hickory Ridse Red Coloursia Mid 2

32. Registrar's Signature

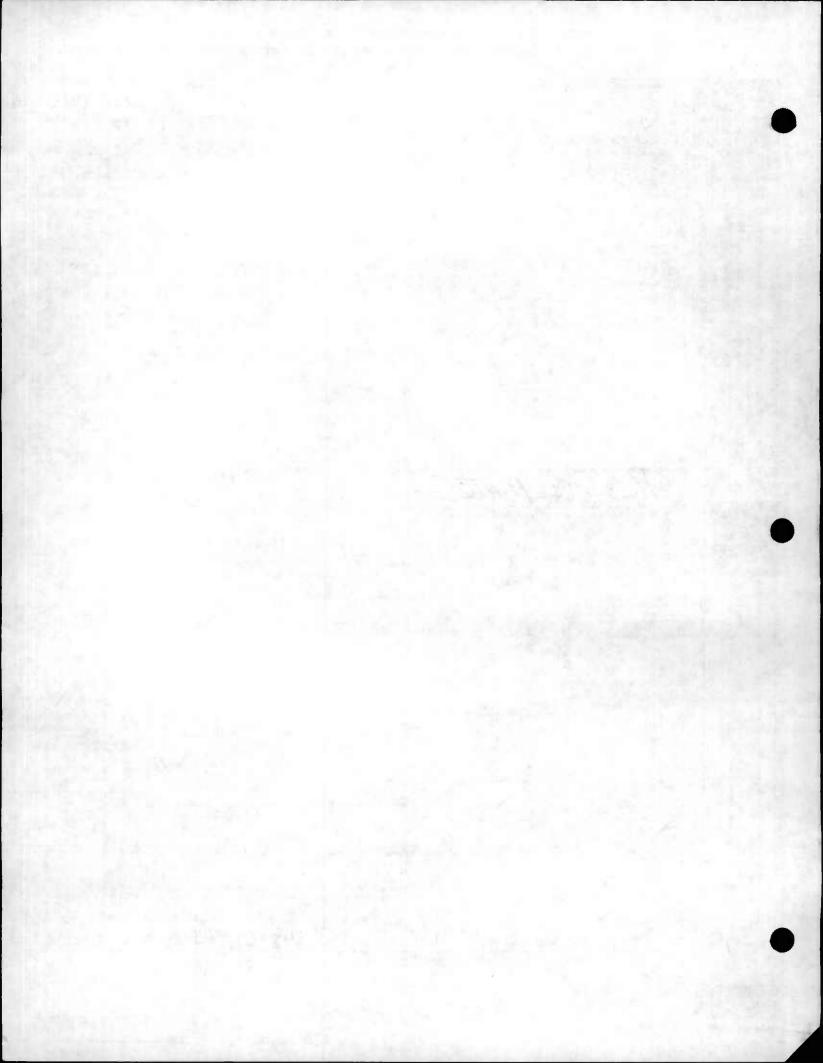
State Registrar

Medical



Mohamed Nur ALIO

	1. Decedent's Nam	a (First, Middla, La	st)		OCITIII	icate of	Dodin	2. Data of De			3. Time of D
sician edical	MOHA	MED N	UR ALI	0				May	Day	2000	10:5
miner	4a Facility Nama (I not institution, giv	re street and number)		300		4b. City, Town, or L	ocation of Death	h 4c. Cour	nty of Death	
		s Commu		pital		Under 1 Yaa	Lanham	_		nce Ge	eorge
ral	5. Social Security N 213-53-		Sax 7. Aga (M M 2□ F 60	(In yrs. last b		onths Days		8. Data of Bird (Month, Da 12-22	y, Year)	9. Birthple	aca (Stata or I
or	Usual Rasidance of		00					12-22	- 39	Soma.	ııa
	10a. Stafe	10b. County		•	own or Locatio					10	d. Insida City
neral Director	Marylan	d Prin	ce Geo.	Riv	rerdal	le					1 StYas 2
F	10e. Street and Nu		m #0	0.1	10	Of. Zip Coda	2.7			of What Count	try?
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Funeral	11. Marifal Sfatus 1 □ Navar Marr	iad 2 Married	Armed Forces?		If Yas	s, specify Cu	Hispanic Origin? (Sp ban, Maxican, Puarto	Rican, etc.)	В	lack, White, e	
by		^	If Yas, Giva Yaar or Datas:		101	Yas 2 No	Specify:		Spec	cify: Blac	ck
leted	(Cno.	15. Decedant's E		18	Ba. Decedent's	's Usual Occu	upation	kina	16b. Kind of	Businass/Inde	ustry
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Be	17. Fathers Nama	(First, Middla, Last) ALIO					18. Mother's Nam	ABDUL		amaj	
5	19a. Informant's N		Type Print)	10	9h Mailing Ac	ddrass (Stra	et and Number or Ru			vn. State 7in	Code)
	ANWAR	NUR -					ood Terr				
in	20a. Mathod of Dis	position		20b. Place	of Disposition	n (Nama of		Data		n - City or Tov	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3 Time of Deeth 35 **Physician** Alexander Lonv 4b. City, Town, or Location of Deeth SOM 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign March 31, 1905 Germany 6. Sex 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1□ M 2□ F 067-38-0572 95 Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flems 23a or 28a-f show Y Yes 2 No Rockville Director Montogomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6121 Montrose Road 20852 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Š 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) filed within al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home parmit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important. If them 27 is marked other any Injury or other traumatic event. 18. Mother's Neme (First, Middle, Malden Sumame) 17. Fether's Neme (First, Middle, Last) Paul Herzberg Elly Gottchalk 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Eleanor Sontag 13531 Flower Field Potomac, MD 20854 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from State Cortland Rural Cemetery 5/2/00 Cortland, NY 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Facility Metropolitan Funeral Service 21. Signature of Funeral Service Licensee 5517 Vine St. Alexandria, VA 22310 finiter the disease, of complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, or hand failure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Cardio -Examiner Due to (or es e consequence of) Physician/Medical Examiner Coronara a Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of) 68760. Due to (or es e consequence of) Box Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed by à 2 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy Completed money performed (irondeficient) disease 1 Yes 2 No 1 □ Yes 2 □ No certificate 25. Wes cese referred to medical depression bling 8 26. Plece of Death (Check only one) exeminer? Hospifal: 1 Inpatient 2 ER/Outpetient 3 DOA Other. Certification: To 1 Yes 2 No 蓋 28e. Dete of Injury (Month, Day Year) 28c. fnjury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Affac Division 5 Pending investigation 1_DNaturel 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hours the Funeral Direction of ò Lactifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) Vilhin 2 To the 29d. Dete signed (Month. Day, Year) 29b. Signeture end title of certifier 29c. License number vant Moule 30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) CONSUELO rvono Montres Load Rockenthe

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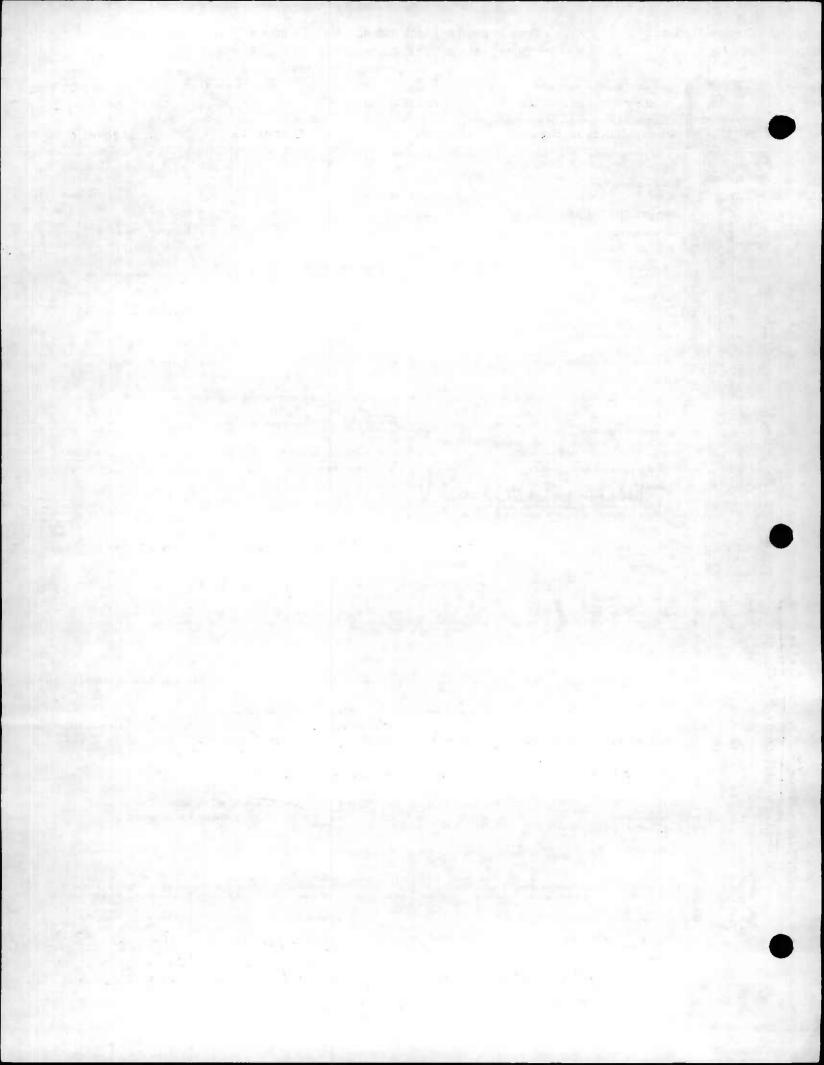
Registrar

31. Dete filed (Month, Day, Year)

MAY 03 2000

32. Registrer's Signeture

exander



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15836

					Certifi	icate of	Death		F	leg. No.	1	1000
		1. Decedent's Name (First, Middle	Last)						2. Date of Dea		V	3. Time of Death
	Physician	Elizabeth Adam	1						Apr 26	2000	Year	12:30AM
	/Medical Examiner	4a Facility Neme (If not institution,		ber)			4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death	12.30AM
7	LAdmine	Holy Cross Hos					C4177	or Co	oring	Monto	romo r	•
	Funeral			7. Age (In yrs. last be	irthdav) If	Under 1 Year		24 Hrs.	8. Date of Birth (Month, Day	Monte		
	Director	565-48-9022 Usual Residence of Decedent	1□M 2√7F	88		onths Days	Hours	Min.	July 31	, 1911	Scot	plece (Stete or Foreign ntry) 1and
	B	10a. State 10b. County		10c. City, Tov	wn or Locatio	on						10d. Inside City Limits
	dary eda	Maryland Montgo										1 ☐ Yes 2 ☐ No
	or 28s-f be notified	Maryland Montgo	mery	Gait	hersb					0- 04	10-10-	A.
	E 50 10					10f. Zip Code				log. Citizen of V	vnat Cour	ntry /
	death with the Maryland ms 23s or 28s-f show Linust be notified at neral Director	301 Russell Aven			10.111	208				United		
	r tems 23 diner mat	11. Marital Status	Armed For		13. Was	s, specify Cub	an, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
20	n 72 hours after death with the Maryla hasturar, or terms 23s or 28s-1 show sitinal Examiner must be notified at leted by Funeral Director	1 ☐ Never Merried 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	od 1 ☐ Yes : If Yes, Give Year or Da		10	Yes 2 No	Specify:			Specify	:	1. 1
Ş	bou part part part part part part part part	15. Decedent			Donadast'	's Usual Occup	ation			16b. Kind of Bu		hite
15	ed within 72 ho ygiens. we then 'natura it, the Medical J Completed	(Specify only highest	grade completed)		(Give kind	of work done NOT use retire	during mos	t of work	ing	100. KING OF BU	31110537111	lousily
12	within the Man	Elementary/Secondary (0-12)	College (1-		omemal		-,			Otam	Home	
9	BIESE m	17. Father's Name (First, Middle, L	ast)	1.	Onemai		18. Mothe	ar's Name	e (First, Middle,			е
an	d be fi	John Court	,	aatan							-,	
₹	ahould b and Manta ametic a	19a. Informant's Name/Relationsh		aston	h Malling As	ddrana /Ctrant		tha	Wa. al Route Numbe	rnock	Ctata 76	Codel
Maryland 21215-0020	and 2 s selft an n 27 fe r ser traus											
	1 and Health em 27 ther tr	David J. Adam,	Son	20b. Plece 0		usculun	Roac	, E	Date Date	, MD 20c. Location -	2081	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: if Item 27 is merins any Injury or other traumatic accs.	1 ☐ Burjat P 🖾 Cremation	B □Removal from S	tate cemete	ery, cremato	ory or other pla		A	pr 27,	200. LOCATION -	City of Te	OWII, State
Ē	dury C	4 Denation 5 Other (Sp		Metro		an Crem		1	2000	Alexand	ria,	Virginia
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	/Medical	Immediate Cause (Final disease or condition	Puntu	rad Abdam	inol 1	Viceus					1	1 / 1
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	d ansid	Sequentially list conditions	b. 10001	Due to (or es a								
C)	axeo In an rial-tr	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		200 10 101 00 0	oonooqoon	00 0.7.						
68760,	eath certificate be assocuted attending physician and if for use as the bunal-transit clan/Medical Examiner	Cause (Diseese or injury that initiated events	c	Due to (or as e	CODERGUAGO	on of).						
9	ed the	resulting in death) Last		Due to (or as e	consequenc	de oi).						
ŏ	nding use a		d									
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P.0.	at the death of by the attended for u	Part II. Other significant condition	s contributing to dea	th but not resulting	in the underl	tying cause giv	en in Part i					o the cause of death?
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Records,									Ode Week		24h W	ere eutopsy findings
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ec	has to ye 2 s											death?
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Division of Vital	Attending Physician: The is refeath. ector: After this certificate he by the funeral director, page this funeral committee the funeral director.	25. Wes case referred to medical examiner?					26. Place	of Deat	n (Check only or	ne)		
	hysicall dire	1 ☐ Yes 2 ☐ No	Hospital: 1 🖾 In	patient 2 ER/O	utpatient 3	DOA Oth	ner: 4□ Nu	rsing Ho	me 5 Resid	enca 6 DOth	er (Specia	(ty)
0	ding Phys h. After this funeral d tion: To	27. Menner of Death 1 X Naturel 5 ☐ Pending	28a. Date of		Time of Injury	28c. Inju	ry at		28d. Describe h	ow injury occur	ed	
0	ath. r: Af re: Af	2 ☐ Accident Investiga	ition	,			Yes 2□	No				
N N	or Attendent destruction by the ertifical	3 ☐ Suicide 6 ☐ Could no determin	ed Zoe. Place	of Injury - At home, fa	arm, street, f	factory, office			28f. Location (S City or Tow		er or Run	al Route Number,
ā	tal or Attending P rs after death. al Director: After t led in by the funera Certification:		Dollow	g, etc. (opecny)					Only or 7011	ii, oluloj		
	To the Hospital within 24 hours To the Funeral completely filled Medical C	29e. Certifier 1X Certifying (Check only 2 Medical E	Physician: To the b	est of my knowledge	e, deeth occ	curred at the tie	me, date an	d place,	end due to the o	ause(s) end me	nner as s	stated.
	n 24 hound n 24 hound he Funer pletely fill	one) 2 Medical E	kaminer: On the bas and manne	er stated.	nd/or Investig	gation, in my c	pinion, dea	th occurr	ed at the time, o	ate and placa,	and due to	o the cause(s)
	To the Mospital or Attending Phyminin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	29b. Signeture end title of certifier	California (California)			29c. Licens	e number		2	9d. Date signed	s (Month,	Dey, Year)
	1	V (M	My.	na		n2	6344			Anril 2	6 20	200
	6	D26344 April 26, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
		Patricia (durn	0	500 Fores			i1270~	Snr	ing 2001	0		
	State	31. Date filed (Month, Dey, Year)		gistrar's Signature	ar GIE	II NU D	TIVEL	phr.	ING ZUJ	.0		
	State - Registrar	MAY 01	2000	Carra	4	1						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth Dev Vaar 29 2000 4:17 am APRIL MARTHA ALSOP 4a Facility Name (If not institution, give street and number) NURSING CENTER 4b. City, Town, or Location of Death 4c. County of Deeth SPECILATY HOSPITAL GLADYS SPELLMAN 8 PRINCE GEORGE 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 1 F Vrs JULY 21 1904 MASSACHUETTS 220-36-9287 Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21401 USA 180 CLAY STREET 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Maritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried Specify: BLACK 1 ☐ Yes 2 No No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) ANNE ARUNDEL CO. Elementery/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION 4 yrs. TEACHER 12th 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) LUCY CROCKER HARRY CHINN 19a. informent's Neme/Reletionship (Type, Print) 19b. Malting Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 11570 S.W.69th CIRCLE OCALA, FL. 34476 GRETCHEN A. CLARK (DAUGHTER) 20b. Plece of Disposition (Name of cemetary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete METRO CREMATORY 5/2/00 BALTIMORE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funarai Service Licensaa 22. Nema end Address of Fecility WM. REESE & SONS MORTUARY, P.A. Reese WEST ST. MD. 21401 821 ANNAPOLIS, Approximata Intervel Between Onset end Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of) Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed' 20 No 1 ☐ Yas 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Piece of Death (Check only one) examiner? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA 27. Manger of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

Physician /Medical Examiner

certificate be executed

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

death.

Depertment of Heelth ar Important: If Item 27 Is any Injury or other trau

Physician

Examiner

Funeral

Director

if Heelth and Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examinar must be notified at

Peges 1 and 2 should be filed within 72 hours efter nent of Heelth and Mentel Hygiene. int: If Item 27 Is marked other than "natural", or ite

3altimore, Maryland 21215-0020

with the Marylend

death

/Medical

Director

Funeral

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Completed

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Examiner Physician/Medical þ Completed Be 2

buriel-trans physician the 98 use 0 signed by the all page 2 should peen has certificate director, this funeral Certification: After 24 hours after deaf Funeral Director: filled in by

> State Registrar

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Medical

30. Neme end eddress of AKU/1 31. Dete filed (Month, Dey, Year) MAY 03 2000

5 Pending investigation

6 Could not be

2 Medica

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end titte of

29c. License number

1 Yes

2 No

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29d. Dete signed (Month, Day, Year)

Location (Street end Number or Rurel Route Number, City or Town, Stete)

charely

32. Registrer's Signeture

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

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AMEND#	19B	5-2-00	AACO	Health	cmh
				State	n Iviai

A١	1END# :	19	B 5-2-00 AACO H	ealth cmh		Certificate of	Death	R	eg. No.	10	1000		
			1. Decedent's Name (First, Middle, Last) 2. Dete of De						eath 3. Tie		3. Time of Deeth		
	Physicia /Medic	al	Frank J. Angelino, Jr.					Month April ocation of Deeth	30 20 4c. County		4:26 pm		
	Examin	ier	230 Lower Mago		9 .	Section 1989	Severna		Anne		ndel		
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs		hday) If Under 1 Year Months Deys	If Under 24 Hrs.				plece (State or Foreigntry)		
	Director		346-28-4443 X 61 Yrs. Months Deys Hours Min. (Month, Day, Fear) Usual Residence of Decedent										
	show the	Director	10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limit										
	No M		AZ Maric	opa So	cott	sdale					1 ☐ Yes 2 ☐ N		
	72 hours after deeth with the Meryland natural', or flams 23a or 28a-f show steal Examinat matt be notified at		10e. Street and Number 7436 Via Campello Del Norte #170 85258 USA										
ep J	ter dee	Funeral	11. Meritei Stetus	12. Wes Decedent Ever in I Armed Forces?	J,S.	13. Wes Decedent of If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - Americ	cen Indien, etc.		
21215-0020	ours after	by	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Yeer or Detes:	355- 559-	1□ Yes 2□No	Specify:		Specify	Wh	ite		
5-0	n 72 hours	Completed	15. Decedent's E (Specify only highest gra		16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of wor	king	16b. Kind of Bu	siness/In	dustry		
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	Hygie ther ther	To Be Co	7. Fether's Neme (First, Middle, Last)			les	18. Mother's Ner	Insurance ome (First, Middle, Maiden Surname)					
an	2 2 2			rank J. Angelino Sr.			Elizab	3.00	ueger				
Maryland	2 should end Men a marke		19a. Informent's Neme/Reletionship (19b.	Mailing Address (Stree				State, Gif	ott, sdale		
	1 and 2 Health e em 27 le		Patricia Angel:	ino / wife	74	36 Via Ca	ampello	Del Nor	te #1	70 A	Z 85258		
ore,	of Her		20e. Method of Disposition	20b.	Plece of cemeter	Disposition (Name of y, cremetory or other pla	ace)	Date	20c. Locetion -	City or To	own, State		
Ē	y of the		1 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specif	Internovel from Stete		ill Cemet		5/4/00	Niles	, IL			
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signatural Survice Licensee 22. Name end Address of Fecility Barranco & Sons PA Severna Park FH 495 Ritchie Hwy Severna Park MD 21146										
		-	23a Barti. Enter the disease or com		-					c MD	21146 Approximate		
i,	Physician	Н	shock, or heert feilure. List only	one ceuse on each line.	Do 1	or error the mode of dy	ing, soon os cardiac	or respiratory on	331,	1	intervel Between Onset end Death		
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ő	e exe		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury							1			
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Box	es that the death ce igned by the attendir be detached for use	Completed by Physician/		•						1			
o.	the de	ysk	Pert II. Other significant conditions of	contributing to death but not re-	sulting in	the underlying cause gi	iven in Part I.				o the cause of death		
٦	that the ded by deta	A A	history of hepato-reval syndrome,					1 U Y	☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkno				
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00	w require s been si should!	lete	chronic obs	ruchive	pu	xmona	my	perlorr	ned?	CO	vaileble prior to empletion of cause deeth?		
of Vital Record	The law ate hes t page 2 s	mo	disease con	onary an	ter	n dice	200	1 D Ye	s 2 No		□Yes 2□No		
la	delan: The	Bec	25. Wes case referred to medical) 55		0	26. Piece of Des	oth (Check only on	-		1 10		
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	ding Phys h. After this funeral di		27. Menner of Deeth ↑ Neturel 5 □ Pending	28a. Dete of Injury (Month, Day Year)	28b. T	ime of 28c. Injury Wo		28d. Describe ho	-				
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Division	or Attendence Directed in by t	Certification:	3 Sulcide 4 Homicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, sfreet, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State)										
١.		edical C	29e. Certifier (Check only one) 29e. Certifier (Check only one) 29 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner estated.										
	within 2 To the comple	Mec	29b. Signature and title of certifier	and menner steted.		29c. Licen	se number	2	9d. Date signe	d (Month.	Day, Year)		
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		1	30. Neme and eddress of person who	completed cause of death (the	m 23e) C	Type Print)	7175)	revno		4 6 14 5		
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					Cei	rtificate of	f Death		Reg. No.			
Physicia	an	Decedent's Neme (First, Middle, Last)							2. Dete of Deeth 3. Month Dev Yeer			
/Medic		WILLIAM BURKE						14		000	8:201	
Examin	er	4e. Fecility Neme (If not institu	ution, give street end nu	umber)			4b. City, Town,	or Location of Deet	4c. Count	y of Deeth	,	
		Woodside					Silver	Spring	Mon	tgome:	ry	
Funeral Director		187M 2□ E			to last birthday) If Under 1 Year Yrs. If Under 1 Year Deys Hours Min.		lin. 8. Date of Bir (Month, De Sept. 8	Birth 9. Birthplace (State of Country) 8,1912 Canada		try)		
ms 23a or 28a-f show r.must be notified at		10e. State 10b. Cou		10c. Cit	y, Town or Lo	ocation	· · · · · · · · · · · · · · · · · · ·		10d. Inside			
r 28a-f show Lnotified at	tor	D.C. No	one	T	Washin	gton D.C			1 ☑ Yes 2 □ P			
128	Director	10e. Street end Number				10f. Zip Code	-		10g. Citizen of Whet Country?			
at be	=	5044 Fulton	St. N.W.	N.W. 20016			016	16		U.S.A.		
Nec must be a	Funeral	11. Marital Status	12. Was Dec	12. Was Decadent Ever in U,S. Armed Forces?		13. Was Decedent of Hispenic Origin? (S If Yes, specify Cuban, Mexican, Puert		(Specify Yes or No				
Exam	by	1 Never Married 2 N	farried 2 Married 1 No. If Yes 2 No.		Viet- am, ERA. 1□Yes 25No Spe			Specify:		Specify: White		
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marked matic e	٥	Vincent		urke				rah				
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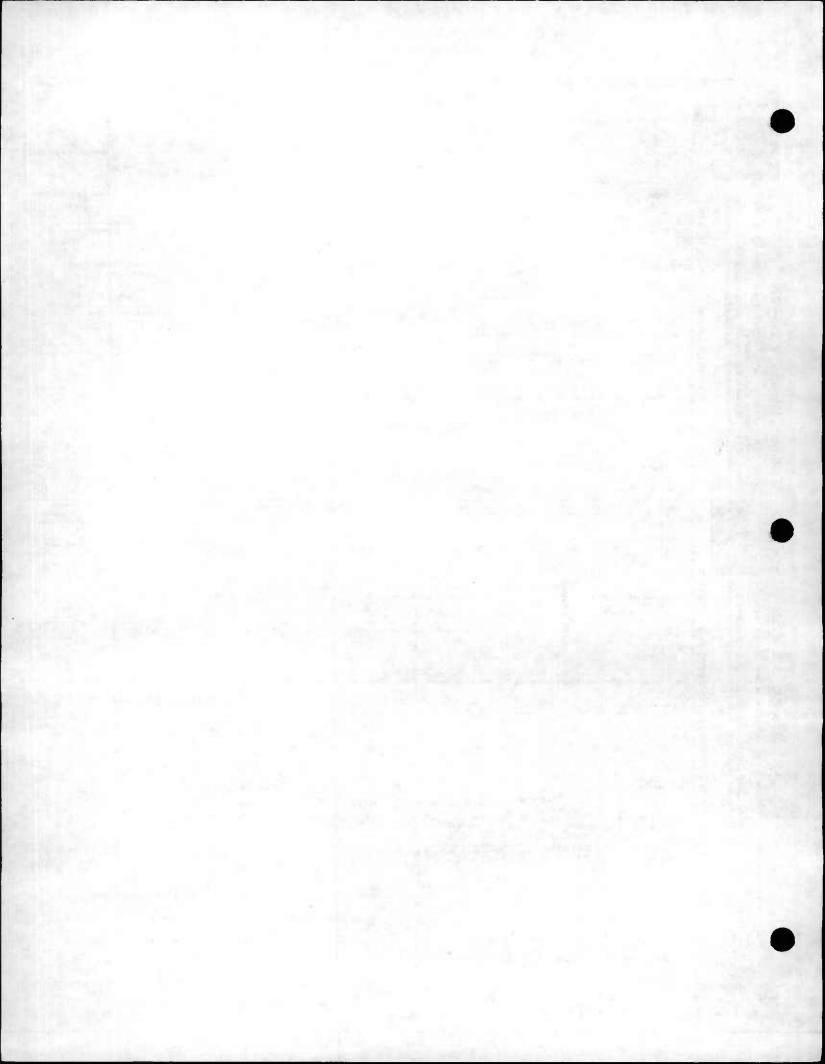
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State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Deeth 3. Time of Death Month Physician 3, 6:36 PM May 2000 Charles Braidwood Bartlett /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Yaer
Months Days If Under 24 Hrs. 9. Birthplace (Stata or Foraign Country) New York 8. Data of Birth (Month, Pay, Year) September 23, 1934 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1⊠M 2□F 65 Yrs. Director 069-26-1915 Usual Rasidence of Decedent the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiana. Important: If Itam 27 ta marked other than "natural", or itema 23a or 28a-f ahow mortural to other traumatic avant, the Medical Examinet must be notified at DDGs. 10b. County 1X Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 1 Pitt Court United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) United States Nuclear Elementary/Secondary (0-12) College (1-4or 5+) Regulatory Commission Nuclear Engineer 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Charles J. Bartlett Eileen Leahy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Thomas G. Bartlett/ Son 814 Crocus Drive, Rockville, Maryland 20850 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Steta May 8, 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 2000 Rockville, Maryland 22. Nama and Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, 21. Signature of Funeral M00689 Rockville, Maryland 20850-2805 had isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Enter to Parti **Physician** /Medical Immediata Causa (Final Disseminated Intravascular Coagulation 4 hours diseasa or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner Multiple Transfusions hours physician and s the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Ruptured Abdominal Aortic Aneurysm hours P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 180 88 attending p signed by the and id be detached for Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Extensive atherosclerosis Records. by 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed peen i Coronary artery disease completion of causa of death? The law page 2 has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital I To the Hospitat or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific compiately filled in by the funaral director. Be 25. Was casa refarred to medical 26. Place of Death (Check only ona) Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Tima of 1 Natural 5 ☐ Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) D24773 May 4, 2000 49 15 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Robert L. Fox, M.D. 9715 Medical Center Drive, Rockville, Maryland 20850 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State Innels! Registrar MAY 05 2000 almerra



30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Don H. Yoblonowitz mo 7404 Executive Mese, Lanham

32. Registrer's Sigpature

20706

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

7 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item pt.II per phys. G783 5/17/00 yg Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Year **Physician** WALTER GREGORY CEPHAS SR, April 25,2000 7:15PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** VA Maryland Health Care System Perry Point Cecil If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 10 M 20 F 56 214-42-8940 Yre Director 11-30-43 CAMBRIDGE, MD Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTO. RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 21133 Herna 23a U.S.A. 3811 FERNSIDE RD Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: 14. Raca - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Merried 1□Yes 2□No BLACK 6 Specify: Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) E.M.S. EDITOR TEL. EQUIPMENT 1.2 permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked othe eny Injury or other treumatic event, page. 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be Walter Cephas Edythia Saunders 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3811 FERNSIDE RD, RANDALLSTOWN, MD 21133 ROSLYN V. CEPHAS, WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete W Burial 2 ☐ Cremetion 3 ☐ Removel from State CROWNSVILLE, CEMETERY 05-01-00 CROWNSVILLE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Lice 22. Name and Address of Fecility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD_ 21207 23a Part | Enter the disease shock, or heart failure. isease, or complications that caused libra. List only only cause on each Approximete Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Immediate Cause Acute Myocardial Infarction Unknown disease or condition resulting in deeth) Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of) 88 for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 MUnknown Hypertension; Gerebrovascular Accident with signed to det Completed by CEREBROVASCULAR ACCIDENT WITH QUADRAPARESIS 24b. Were autopsy findings eveileble prior to 24a. Was an autopsy Quadraparesis; Fracture Right Leg completion of cause of death? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifies Month April 25, 2000 D42800 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Thomas Biondo, M.D., VA Maryland Health Care System, Perry Point, MD 21902 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State



DHMH 16 Rev 6/95

Registrar

MAY 1 7 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15843

				Certif	ficate of l	Death			Reg. No.			
	1. Decedent's Name (First, Mid	die, Last)						2. Date of D	eath	Year	3. Time of Death	
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To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the funeral Director.	(Check only 2 Medical one)	i Examiner: On the ba	sis of examination en	d/or invest	tigation, in my o	pinlon, dea	ath occurr	ed at the time	, date and placa,	and dua to	tha causa(s)	
Vithin Forth	29b. Signeture and title of certif	ier			29c. Licens	e number			29d. Date signe	d (Month, D	ay, Year)	
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	30. Name and address of person ANDREW G	ONDOW MD	2003 Me	dicz	1 Poury	, Ste	100	Annzp	olis, N	10 2	1401	
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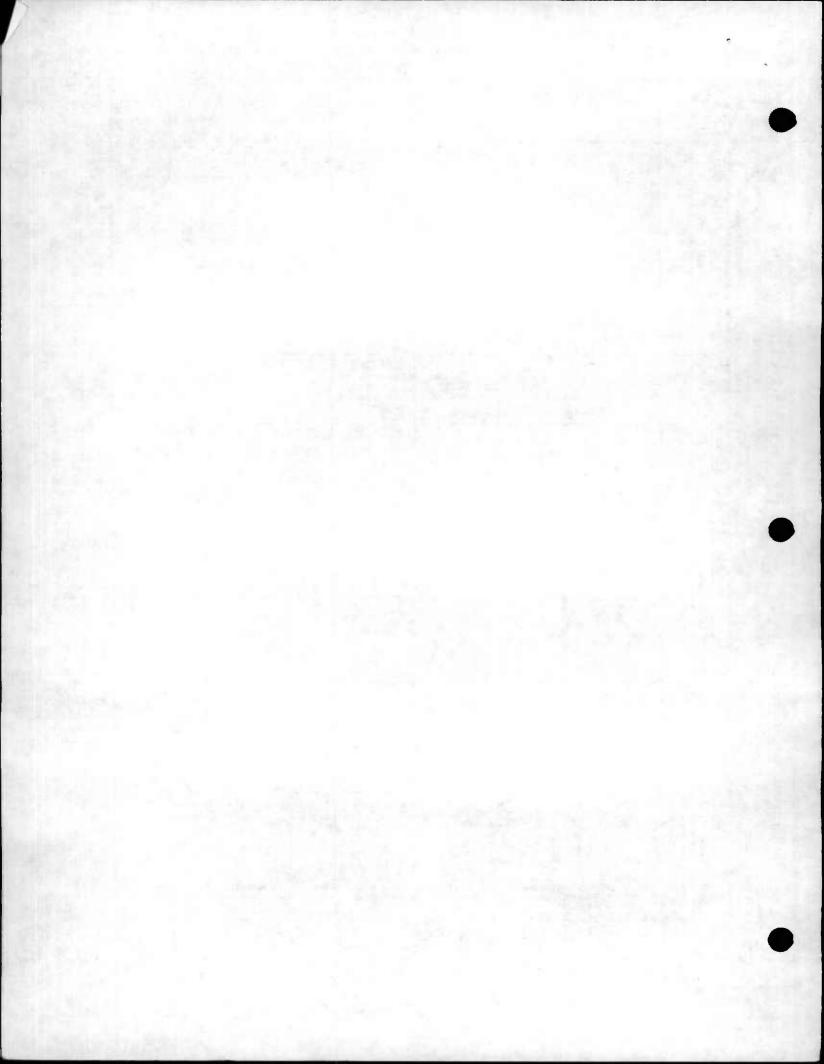
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

4-11-1	Decedent's Neme (First, Middle, L	Reg. No.			3. Time of Deeth								
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/Medical Examiner	4a Facility Neme (If not institution, g	ocation of Deat		ty of Death	12110111								
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Funeral Director		Sex 1□M 2√F 7. Age	(In yrs. last birthd	Months Devs	Hours Min.	8. Date of Bir Month, Da 07 25	1914	9. Birthplece (State or Foreign Country) Harnett Co., NC					
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ath with the Maryier 23a or 28a-f show wat be notified at iral Director	10e. Street end Number 4113 54th Stre				710		10g. Citizen of Whet Country? USA						
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Exc. other must be notified at pace. To Be Completed by Funeral Director	11. Meritel Stetus 1 □ Never Married 2 □ Merried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes 2 No Specify: 14. Race - American Indien, Bleck, White, etc. Specify: White									
	15. Decedent's I (Specify only highest g	Education rade completed)	16a. De	cedent's Usuel Occup ive kind of work done a. DO NOT use retired	ation during most of work	ing	16b. Kind of	6b. Kind of Business/Industry					
	Elementery/Secondery (0-12)	College (1-4or 5+)	omemaker	,	Own Home							
	17. Father's Neme (First, Middle, Las	(1)			18. Mother's Nem	e (First, Middle							
	Bernice Frank	lin Wood			Georg	ianna P	leasant						
	19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert L. Copenhafer, Husband 4113 54th Street, Bladensburg, MD 20710												
	20e. Method of Disposition					Dete	20c. Location		own, Stete				
	Donation 5 Other (Specify) 21. Signature of Funeral Service Logice Connection 3 Removed from State Bethsaida Church Cem. 22. Nama and Address of Facility												
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4	23a. Pert1. Enter the diseese, or conshock, or heart failure. List only	nplications that caused to y one cause on each line	death. Do not	enter the mode of dyir	ng, such es cardiac	or respiretory e	rrest,		Approximete Intervel Between Onset end Death				
Physician / /Medical	Immediate Cause /Filest												
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To the vithin To the comp	290. Signature and still of certifier	MMM	1.10	29c. Licens	e number		29d. Dete sign	ned (Month.	Dey, Year)				
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4	30. Name and address of person who	completed ceuse of dea	th (Item 23e) (Ty	De, Print)	musla	Pd. P	2 ockui	10	107085				
	31. Dete filed (Month, Day, Year)	301100	113.00	101 0000	MOUNT	10011							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Glen Howard Cline, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18 2000 10:45 P.M. Glen H. Cline Jr. April /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Eastbound I-70 at I-81 Hagerstown If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1₩ 2□ F 369-32-7885 64 Director 17, 1935 Saginam, MI, Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. tnside City Limits 10b. County show r than "natural", or flame 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director Bay Bay City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Stanton St. 48708 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritat Status 1 ☐ Yes 2 ☑ No It Yes, Give 1 ☐ Never Married 2 € Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) 10 Owner Painting/Heating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Glen Cline Dorothy Dinninger 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Cline - Wife 400 Stanton St. Bay City, MI. 48708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/21/00 Alexandria, VA. Metropolitan Crematory 21. Signature of Funaral Service Licensae 22. Nama and Address of Facility Metropolitan Funeral Service Alexandria, VA 22310 nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, non each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Examine attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 6 20 No 3 Probably 4 Unknown 1 Yes b Records. 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed hes Yes certificate Division of Vital 25. Was casa referred to medical examiner? Be 26. Place of Death (Check bnly one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Scene Hospital: 2 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Nonth, Day Year) 27. Manner ot Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding Pl within 24 hours after deeth. To the Funeral Director: After it completely filled in by the funera Certification: pedestrian struckly auto 40 1 Natural 5 Panding investigation 1 Yes 2K Accident 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide I-70 and I-8 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Sig O.C.M.E. April 20, 2000 sss of person who completed caus vi death (Item 23a) (Type, Print)

Registrar

State

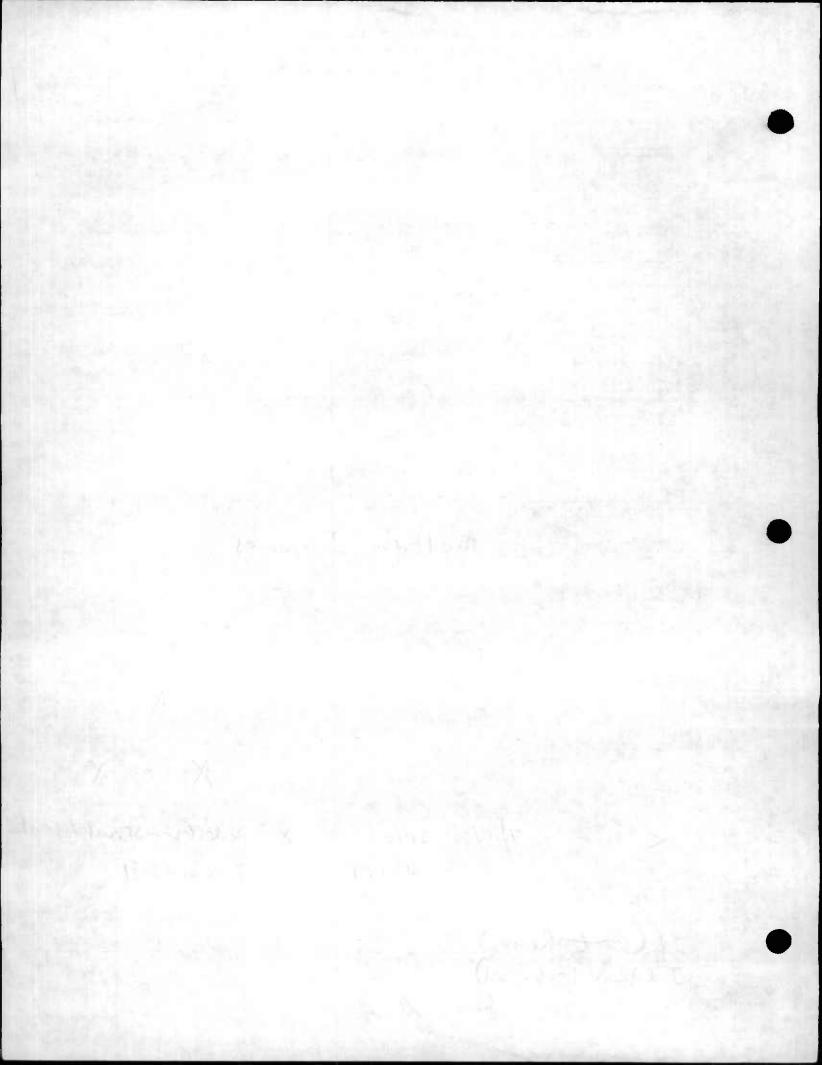
31. Date tiled (Month, Day, Year)

32. Registrar's Signature

2000

03

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 15816

	Certificate of Death Reg. No.											
Physician	1. Decedent's Nama (First, Middle,	2. Data of De Month	ath Day	Year	3. Time of Death							
/Medical	Frank G. Capon	aletti					May 1,	2000		1:15 AM		
Examiner	4a Facility Nama (If not institution,	give street and num	or Location of Death	4c. County	of Death							
	1911 Dennis Ave		r Spring		tgomer	У						
Funeral			. Age (In yrs.		If Under 1 Year Months Days		rs. 8. Data of Bir in. (Month, Da	ta of Birth 9. Birthplace (Stete or Foreign Country) 22, 1923 Washington, De				
Director	577-48-0845	1⊠M 2□F 77					Apr. 22	2, 1923 Was		ngton, DC		
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filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show ant, the Mexical Examiner must be notified at a Completed by Funeral Director	10a. Stata 10b. County			100	I. Inside City Limits 1 ☐ Yas 2 ☒ No							
	Maryland Montgon											
	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country	17		
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Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic avant, the Medical Examiner must be nothing at pace. To Be Completed by Funeral Director	11. Maritel Status	12. Was Deced	dent Ever in U	,S. 13. V	Vas Decedent of Yes, specify Cui	Hispanic Origin?	(Specify Yes or No erto Rican, atc.)	- 14. Rac	e - Amarican			
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	15. Decedent's (Specify only highest			16a. Deced	ent's Usual Occu	pation	undring.	16b. Kind of Bu	usiness/Indus	stry		
	Elamantary/Secondary (0-12)	Collega (1-	4or 5+)	life. L	OO NOT use retin	e during most of v ed)	on and					
	11				Owner		Tire Company					
	17. Fathar's Nama (First, Middle, L.	ist)				18. Mother's N	lama (First, Middle,	Maiden Suman	10)			
	Paul Caporalett					ELizab	eth Gesev	aldi				
	Paul Caporaletti ELizabeth Gesevaldi 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or T						er, City or Town,	State, Zip C	ode)			
27 le	Jennie Caporale	ti / Wife	2	1911	Dennis A	Avenue,	Silver Sp	ring, M	arylan	d 20902		
ant: If item ary or othe	20a. Mathod of Disposition		20b. F	Place of Dispos	sition (Name of		Data	20c. Location -	City or Town	n, Stata		
00	1 ☑ Buriel 2 ☐ Cramation		IAIA		natory or other plants		5/05/00	Silwar (Snring	, Marylan		
5	4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		ines-Rina									
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) along	Lome		S	ilver Sp	oring, Ma	aryland	20904				
	23a. Pert1. Entar tha disease, or shock, or haart failura. List	omplications that can nly ona causa on aa	used tha deat ch lina.	h. Do not ente	er the mode of dy	ring, such as card	iac or respiratory a	rrest,	A In	pproximata itervei Between		
sician	Eller Anna Land								0	nset end Deeth		
edical	Immediata Causa (Final disaasa or condition	Metastatic carcinoma to bone 6 month										
iner	rasulting in daath)	Due to (or as a consequence of):										
e e	and the state of t	Car	Carcinoma of the prostate 4									
ial-transit	Sequentially list conditions	b	b. Due to (or as e consequence of):									
EX EX	Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or injury											
s the burial-transit Examir	Inat initiated evants	C. Dua to (or as a consequence of):										
e as the bu Medical	rasulting in death) Last	Lua to (or as a consequence or):										
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etached for use	5 10 50 10 m						1 000 000			7.700.4		
chec	Part II. Other significant condition	s contributing to dea	ith but not res	uiting in the ur	idenying cause g	iven in Part I.				he cause of death?		
detached of Physic	arterioscleroti	c heart d	isease				10	Yes 21 No	3 Probe	bly 4 ☐ Unknown		
م گر							04-144		24h Ware	sutopsy findings		
page 2 should to	carcinoma of th	e colon					24a. Was	an autopsy ermed?	avail	able prior to		
mple									of de	ath?		
Page Com							10	Yes 20 No	101	Yas 2□ No		
rector, page	25. Was casa referred to medical					26. Place of D	Deeth (Check only o	ne)				
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5 7	27. Mannar of Deeth	28a. Data of	Injury	28b. Tima of	28c. Inju		-	how injury occur				
tha funeral cation:	1 Natural 5 Panding 2 Accident invastiga		, Day Year)	Injury		Yes 2 No						
ed in by the funeral Certification:	3 ☐ Suicida 6 ☐ Could no	t be ne Place	of Injury - At he	ome, ferm, str	et, fectory, office)		Street and Numb	er or Rural F	Route Number,		
ert in	4 Homicide	building	g, atc. (Specif	y)			City or To					
Ö	29a. Certifier 1₩ Certifying	Physician: To the h	net of mulur-	wladaa daath	nonurrad at the	lime data cod cla	no and due to the	causals) and m	oner se etct	ed		
completely filled in		Physician: To the barniner: On the barniner	is of examina									
To the Funeral completely filled	29b. Signature and titla of certifiar	and manne	or stated.		20a Linea	nse number		29d Data since	d (Month De	v Yearl		
528	250. Signaturation title of central	TOO THURSDAY	29d. Data signed (Month, Day, Year)									

State Registrar

31. Deta filed (Month, Day, Year)

30. Name and eddrass of person who complated causa of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

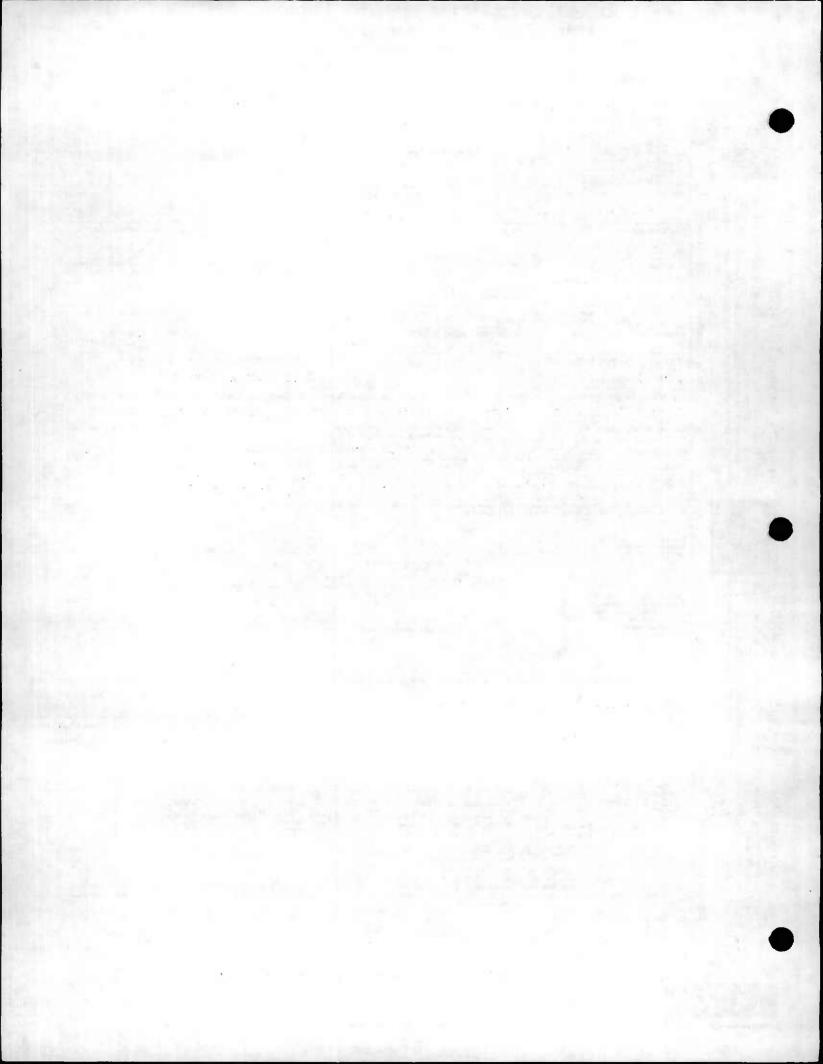
18

Israel Spector, M.D. 12001 Ferrara Drive, Wheaton, Maryland

D11200

May 1, 2000

20902



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death 6:50PM **Physician** May rurae 2000 /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hospital Montgomery Silver Spring Cross 8. Date of Birth (Month, Day, June 19 If Under 1 Year | If Under 24 Hrs. Sinthplace (State of Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1⊠ M 2□ F 217-28-9299 Yrs. 67 1932 Director Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2K No Director Maryland Montgomery Silver Spring 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 11700 Old Columbia Pike 20904 Berra 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes:1 9 4 9 − 1 9 5 3 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantel Status 14. Race - American Indien. Bleck, White, etc. filed within 72 hours after 1 ☐ Never Memied 2 ☑ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Truck Driver Fuel Oil Industry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Nem 27 is merised offs any Injury or other traumatic event 8058. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be George G. Caldwell Helen McDonald Kesecker 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Alice F. Caldwell / Wife 11700 Old Columbia Pike, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 05/03/00 Brentwood, Maryland 4 Donation 5 Other (Specify) Fort Lincoln Crematory 21. Signature of Funeral Service I 22. Name and Address of Facility Hines-Rinaldi Funeral Home ach 11800 New Hampshire Avenue Silver Spring, Maryland or the disease, or complications that leaved the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, need failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** grdieny Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseasa or injury that initieted events resulting in deeth) Lest Due to (or as e consequence of): P.O. Box 68760, Due to (or as e consequence of) been signed by the should be detached Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Were autopsy findings eveilable prior to Completed 24a. Was en eutopsy completion of cause of death? Yes 2 No 1 Yes 2□ No certificate Division of Vital or Attending Physician: director, 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? As Hospital or As. 24 hours after death.

As Director: After the further further for the further for the further for the further for the further for the further for the further further for the further furth 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation in 24 hous.
the Funeral Director filled in by the 6 ☐ Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) and menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one)

State Registrar

10

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Menglie

2000

ratta

32. Registrer's Signeture

DHMH 16 Rev 6/95

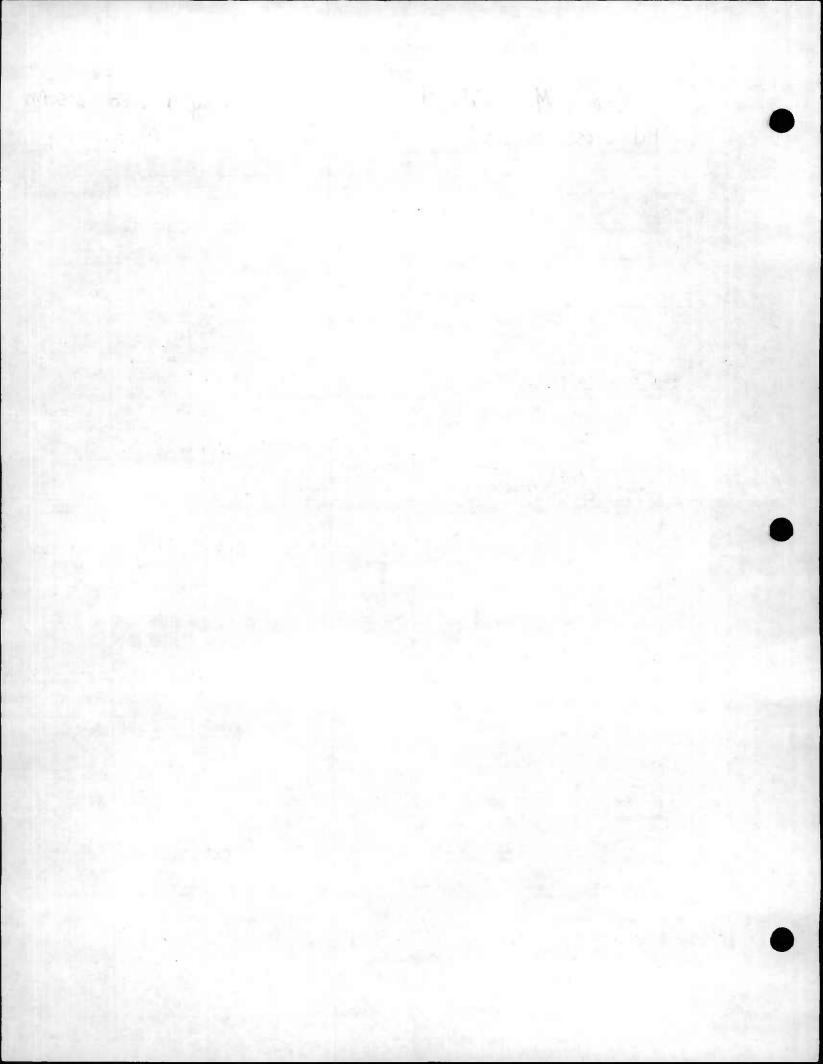
29c. License number

D0038262

29d. Date signed (Month, Dey, Year)

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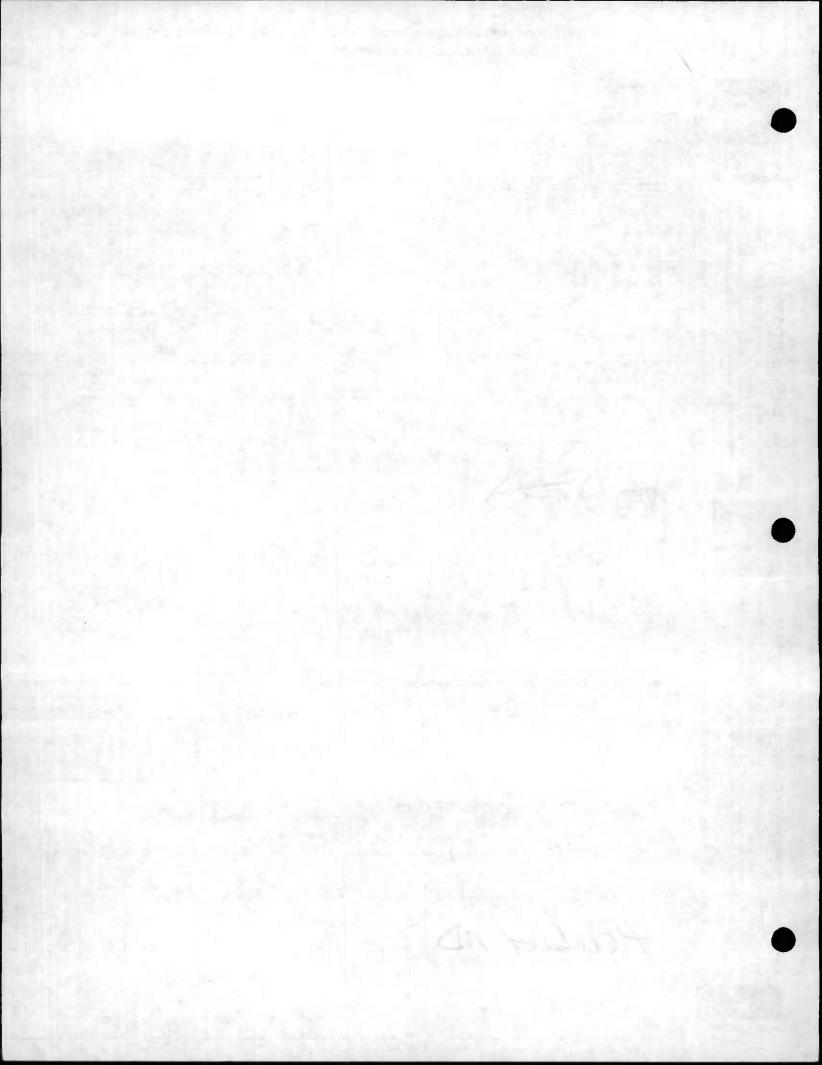


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State of Maryland / Department of Health and Mental Hygiene

icate of Death

	Carlotte of			Cer	tificate o	t Death		Reg. No.					
Physician /Medical	1. Decedent's Name (First, Middle Manue1	Alberto			Caldero	n	2. Dete of D Month May	Dey	Yeer	3. Time of Death 3:25PM			
Examiner	4e Fecility Neme (If not institution		n <i>ber)</i>			4b. City, Town, or		th 4c. County	of Deeth				
-	14511 Layhi11				# 11-d4 V-	Silver	Spring	pring Montgomery					
* Funeral Director	5. Sociel Security Number 579–72–5098	6. Sex 1⊠ M 2□ F	7. Age (In yrs. I 67	last birthdey) Yrs.	If Under 1 Ye Months Dey		(Month, D	irth e <i>y, Year)</i> r 27 , 1932		olece (Stete or Foreign ntry) uador			
9 .	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location												
or 28e-f sho be notified at Director	Maryland Montgo	mery			er Spring								
fler death with the Maryland r flams 23a or 28e-f show siner must be notified at Funeral Director	10e. Street and Number				10f. Zip Code	9		10g. Citizen of V	Vhet Cour	ntry?			
	14511 Layhill F				20906 United States 3. Was Decedent of Hispenic Origin? (Specify Yes or No- 14. Raca - American Indian.								
	11. Meritel Status	Armed Fo		S. 13. V	Vas Decedent of Yes, specify C	of Hispenic Origin? (uben, Mexicen, Pue	o- 14. Rac Bled	a - Americ k, White,					
ours after	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	ied 1 Tes If Yes, Giv Yeer or Da	/e	1	XYes 2□ N		uadoran	Specify	Whi	te			
Destinitions, mail yield A. I. A. I. D. D. D. Desmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or hems 23a or 28a-f show Important: If them 27 is marked other than "natural", or hems 23a or 28a-f show Important: If them 27 is marked other than Medical Examinar must be notified at other. To Be Completed by Funeral Director	15. Decedent (Specify only highes	's Education et grade completed)		16a. Deced (Give	ent's Usual Oct kind of work do	cupetion ne during most of w ired)	orking	16b. Kind of Bu	usiness/Ind	dustry			
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	17. Father's Name (First, Middle, Cesar Calderon	Last)		e, <i>Maiden Sume</i> n Manozalv									
and Sand	19e. Informent's Neme/Reletionsh	ber, City or Town,	Stete, Zip	Code)									
and 2 and 2 and 2 and 2 is no 27 is no 27 is	Juana Calderon	/ Wife				1 Road, S	Silver S	pring, M	D 209	906			
of Hear	20e. Method of Disposition		20b. P	lace of Dispos	sition (Neme of netory or other p	olece)	Dete	20c. Location -					
milt. Pages partment of the injury or o	1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (St		Stete			Cemetery	May 5,	Silver Marylar	Spri	ng,			
permit. Pa Departmen Important: any Injury obcs.	21. Signeture of Funerel Service	Licensee A	Jul							neral Home/			
a see a	butter / -	71	M00689	Ro	ckville	kville, N	0 West	Montgome	ry Av	venue,			
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Examiner	disease or condition resulting in death) e. Arrythmia Sudden												
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slcian buria	Cause (Diseese or injury that initieted events	c. Seve		rtension as a consequence of):									
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tha cythe	Part II. Other significant conditio	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.											
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sician certifi lirector	25. Wes case referred to medical examiner?	Hospitel:		L'arente		Other:	eeth (Check only						
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phrain ours	29e. Certifier 1⊠ Certifying	n Shuafalan, Ta tha	boot of my know	uladaa daath	annumed at the	time date and alo	and due to the	a sound(a) and my		stated			
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page. Medical Certification: To Be Com		g Physician: To the Examiner: On the ba and menr			estigation, In m	y opinion, deeth occ		, dete end pleca,	end due t	o the ceuse(s)			
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15	F. Ol	Siot	M		D31	319		May 2,	2000)			
	30. Neme end eddress of person	who completed caus	e of deeth (Item	23a) (Type, I					14				
	Loreto S. Albio	1, M.D. 8	218 Wis	consin	Avenue	, Suite 1	03, Bet	hesda, M	D 208	314			
· State Registrar	31. Dete filed (Month, Dey, Year) MAY 05	32. R	egistrer's Signer	turo	Moore								
3	WALDS			,	PL 694	-							

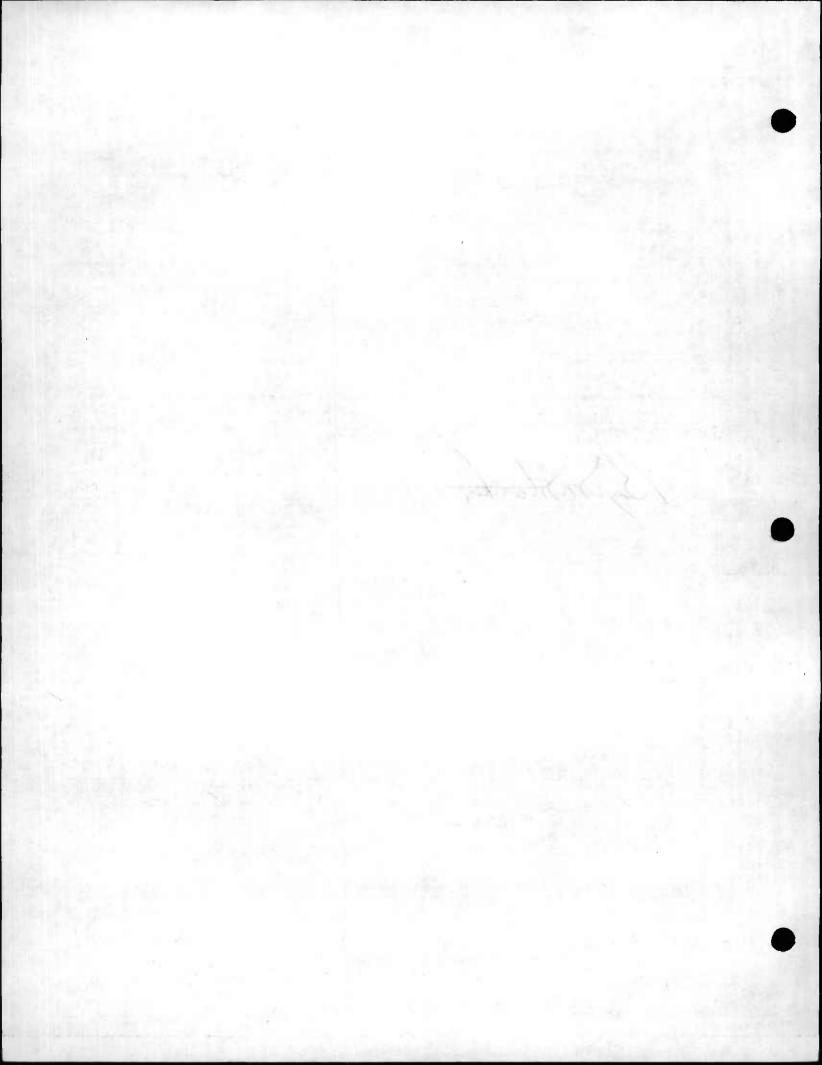


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death May 2000 **Physician** 2, Natalie Y. Cohen /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 14609 Carona Dr. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth AMONTH, Day, Year APril 10,19 40 Country New York 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 10 M 20 F Days Hours 100-30-7340 60 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 □ No Director Maryland Montgomery Silver Spring or 28a-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20905 United States 14609 Carona Dr. Nerns 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 No If Yes, Give 14. Race - American Indien. 11 Maritel Status 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is merited other than "netural; or (te any injury or other traumetic event, the Medical Examines 3altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementery/Secondery (0-12) College (1-4or 5+) Teacher Education 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumeme) Be Lee Slotnick Benjamin Kirshner 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 14609 Carona Dr. Silver Spring, MD. 20905 Martin H. Cohen 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 DRamoval from State 5/2/00 Olhey, MD. Judean Memorial 4 Donetion 22. Name and Addrass of Facility Takoma Funeral Home. 254 Carroll St. NW Washington, DC. 20012 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or part feiture. List only one cause on each line. Approximete tnterval Between Onset and Death Physician Immediete Ceuse (Final disaase or condition resulting in death) /Medical Examiner Due to (or as a consequenca of) Head Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tren Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequence of). Records, P.O. Box 68760. Dua to (or as a consequence of): page 2 should be detached Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 Yee 2 No à 24b. Wera autopsy findings available prior to completion of ceusa of deeth? Be Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital director, 25. Was case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated. (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the ceuse(s) and manner detect. To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 140 ss of person who completed cause of death (tem 23a) (Type, Print) 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State 05 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #29c,5/4/2000, BMW, Montg. Co Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY ^{Day}2000 10 **Physician** 1, ANN REEVES PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner **GENERAL** MONTGOMERY MONTGOMERY HOSPITAL OLNEY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV. 26, 1919 9. Birthplace (State or Foreign NEW YORK 7. Age (In yrs. last birthdey) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 K F 80 072 03 6308 Yrs Director Usuel Residence of Decedent with the Manyland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Wed or Examiner must be notified at once. 10a. State 10b. County SANDY SPRING MONTGOMERY MD. 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 UNITED STATES 1014 OUAKER KNOLL ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuai Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AL FRED KENNEDY REEVES MARJORIE ANN BUELL 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 966 BARTNICK ROAD, GENOA, NEW YORK 13071 HANNAH COPE RICHTER, DAUGHTER 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 SCremetion 3 Removal from State METROPOLITAN CREMATORY 5/3/00 ALEXANDRIA, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanses 22. Name end Address of Fecility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlac or respiretory arrest,

A shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CARDIAC diseese or condition resulting in death) Examiner Physician/Medical Examiner ISSECTION AORTIC ARC law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest physician and s the burial-tran Due to (or as e consequence of): P.O. Box 68760, Due to (or as a consequence of) attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SUGU Records, 2 24b. Were eutopsy findings aveilable prior to completion of cause of death? should 24a. Was an autopsy Completed s certificate has t director, page 2 s The 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital ial or Attanding Physician: The safer death.

In Director: After this certificate ed in by the funeral director, pa Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Cutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 WNatural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

10

24 hours af Funeral D etaly filled in Hospital

To the Hosp within 24 ho To the Fune completely fi

State Registrar

edical

29a. Certifier

31. Date filed (Month, Day, Year)

29b. Signature and little of cartified



DO5809

29c. License number

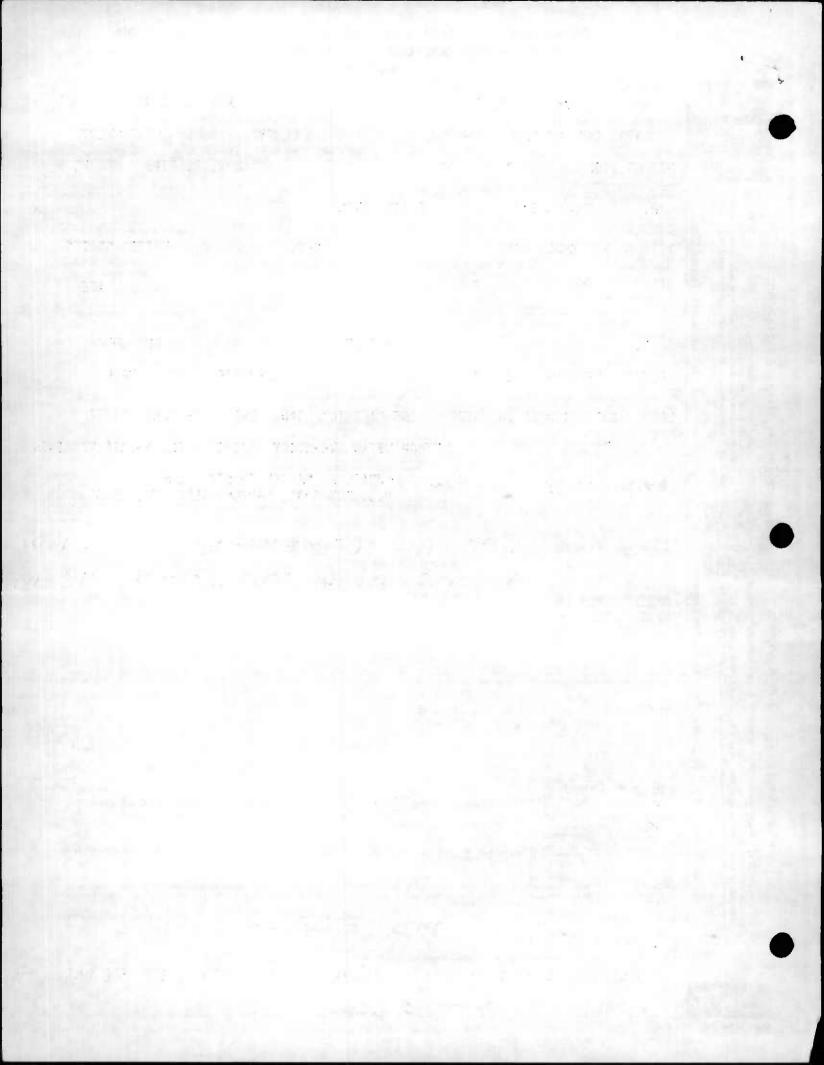
1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Yeer)

and address of person who completed cause of death (Item 23a) (Type, Print)

OLNEY RD. OLNEY MD 20832

2000 MAY 04



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Judith Α. Carswell 29 2:00 AM April 2000 /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE H Under 1 Year H Under 24 Hrs. 8. Data of Birth (Month, Day, May 10, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 1943 1□ M 23F Washington, Yrs 217-42-4156 56 DC **Director** Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Director 28a-t Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizan of What Country? hems 23s or 1905 Merrifields Drive 20906 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. filed within 72 hours after 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yas 2 ☑No If Yas, Giva Year or Dates: 3altimore, Maryland 21215-0020 ò 1 ☐ Yes 2 IXNo Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16h Kind of Business/Industry ith and Mental Hygiene. 27 is merked other than " r traumatic event, the Mes Elemantary/Secondary (0-12) College (1-4or 5+) Systems Analyst CIA permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event 17. Fathar's Name (First, Middla, Last) 18. Molhar's Nama (First, Middle, Maiden Sumama) Jack Pearson Evelyn Crowell 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Steve Carswell / Husband 1905 Merrifields Drive, Silver Spring, Maryland 2090b 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removal from Stata Gate of Heaven Cemetery 05/02/00 Silver Spring, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue 21. Signatura of Funeral Sarvice Licansee Silver Spring, Maryland 20904 23a. Part1. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart feilure. Dist only one cause on each line. **Physician** /Medical Immediata Ceuse (Finel disaasa or condition rasulting in death) neumonia Examiner Due to (or as e consequence of): Physician/Medical Examiner Cance The lew requires that the deeth certificets be executed Sequantially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last pue Dua to (or as a consequence of): the burial-trar P.O. Box 68760. Due to (or as a consequence of) USB 85 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records. ģ should be 24b. Were autopsy tindings available prior to Be Completed 24a. Wes an autopsy performed? Deen completion of cause of death? 2 10 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director. 25. Was casa reterred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To this funeral 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Naturel 5 Panding To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 1 Yas 2 No 2 Accidant invastigation 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred et tha time, data end place, and due to the cause(s) and menner stated. 29a. Cartifiar (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) ROCKVILLE MO

DHMH 16 Rev 6/95

State

Registrar

15245 SHADY GREVERD

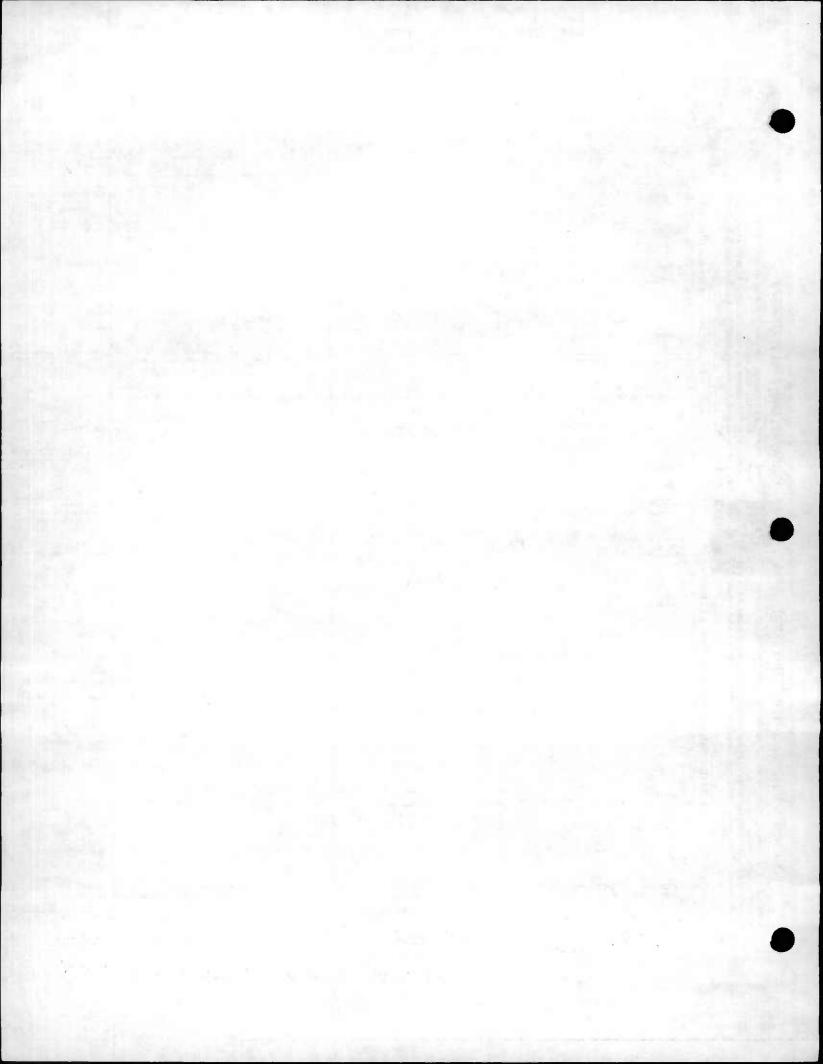
S. CHANACES

2000

32. Registrar's Signatura

31. Data tiled (Month, Day, Year)

MAY 02



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiefie Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** 28, ALLEN CHESTER APRIL 2000 3:50 A. M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL BETHESDA MONTGOMERY ff Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Deys Hours 1 M 2 F Yrs. Director 071-22-4213 23, NOV. NEW YORK Usual Residence of Decedant the Marylend 10a. Sfata 10b. County 10c. City, Town or Location 10d. Insida City Limits notified at 1 Vas 2 □ No Directo MARYLAND MONTGOMERY 28e-f ROCKVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 death with ma 23a or 11200 EMPIRE LANE 20852 U. S. A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healin and Medical Hygiene. Important: If them 27 is marked other than "natural; or the any Injury or other traumatic event, in a Medical Examin 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yas 2 ☐ No If Yes, Giva Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ COLLEGE PROFESSOR EDUCATION 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Sumama) Be THEODORE CHESTER CONSTANCE SAFFIR P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) BEATRICE CHESTER - WIFE 11200 EMPIRE LANE, ROCKVILLE, MARYLAND 20852 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burlal 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) JUDEAN MEMORIAL GARDENS 4/30/00 OLNEY, MARYLAND 21. Signature of Funaral Sarvice License 22. Nama and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or havet failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediata Cause (Finel disaasa or condition resulting in death) /Medical CARDIAC ARREST **Examiner** Dua to (or es a consequance of): Examiner MYOCARDIAL INFARCTION or Attending Physician: The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in death) Lest burial-tran pue Dua to (or es e consequança of) P.O. Box 68760. physician Physician/Medical the th Dua to (or es a consequence of). for use as Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco usa contributa to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown POSSIBLE URINARY TRACT INFECTION of Vital Records. þ should be Completed 24b. Wara autopsy findings evailable prior to 24a. Wes an eutopsy performed? peen complation of cause of death? has page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate funeral director, Be 25. Wes case raferred to medical examinar? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Medical Certification: To 1 TYes 2 No 1 Inpatient 2 XER/Outpatienf 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Panding Invastigetion Division 1 Nefural 2 ☐ Accidant 1 ☐ Yes 2 ☐ No within 24 hours after deeth. To the Funeral Director: A 6 Could not be detarmined 3 Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end mannar as stated.

2. Medical Examiner: On the best of examination and/or invastigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and mannar stated. 29a. Cartifiar completaly (Check only one) \$ 29b. Signatura and titla of certifie 29c. Licanse number 29d. Date signed (Month, Day, Year) aln APRIL 28. 2000 D20367 30 nd eddrass of person who complated causa of daath (Itam 23a) (Type, Print) SOEL KALMAN, M. D. 611 EXECUTIVE BLVD., ROCKVILLE, MARYLAND 20852

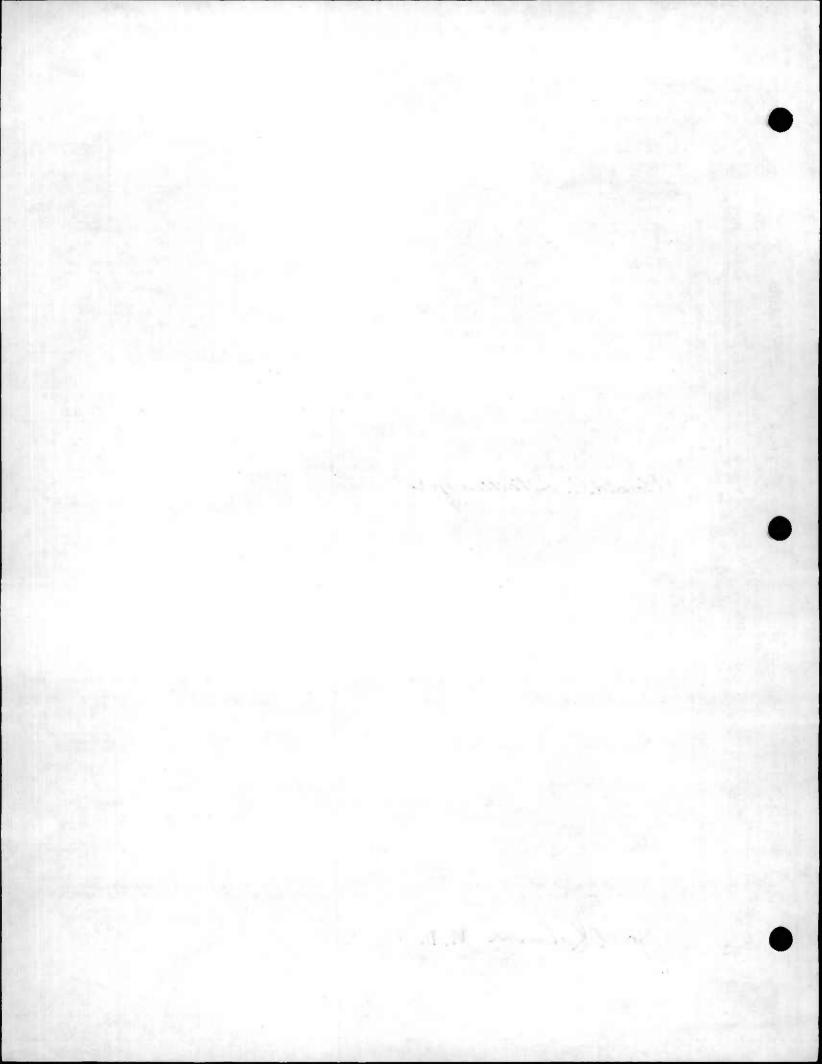
Registrar **DHMH 16 Rev 6/95**

State

31. Data filed (Month, Day, Year)

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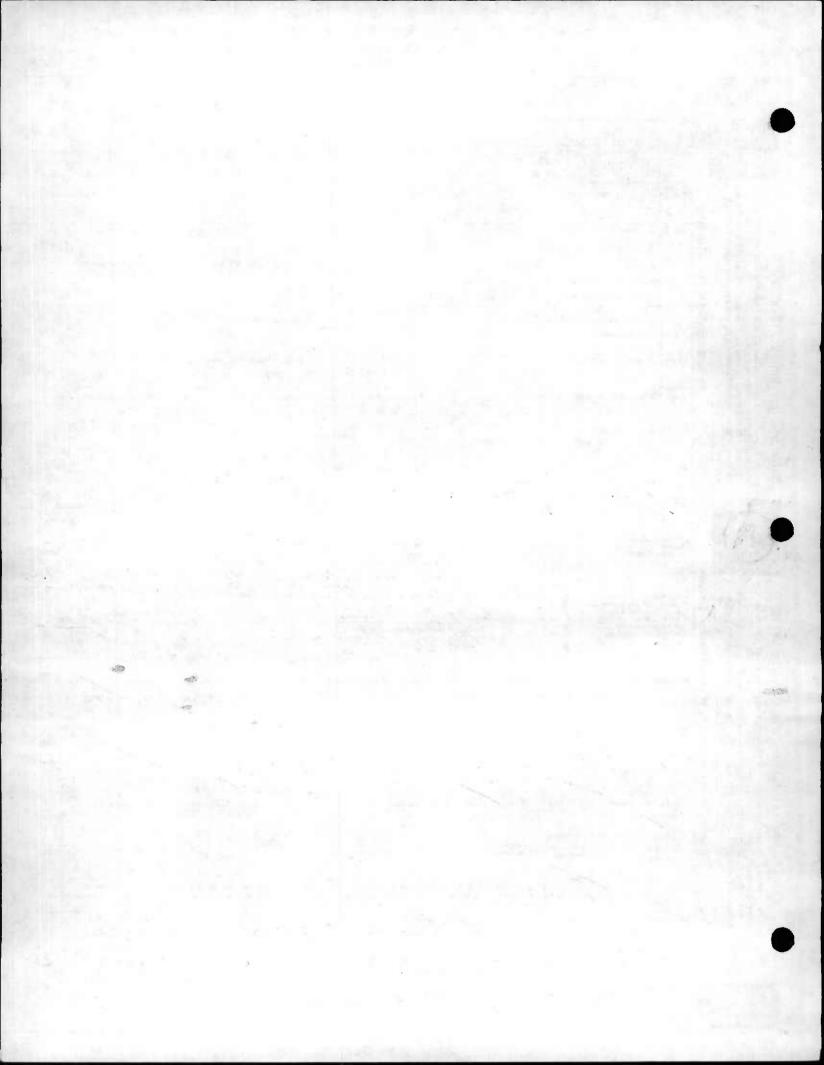
32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Charles John DeManss 25, April 2000 1:15 PM /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1⊠M 2□ F Yes 216-16-6607 78 May 2, 1921 Director Maryland **Usual Residence of Decedent** 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland | Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a or daeth with 518 Broad Creek Dr. 21666 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after or ann of Health and Mental hygiana. Int if Itam 27 is marked other than "natural, or Ner Iny or other traumitic avent, no Marical Emerical 1 □ Never Married 2K Married 1⊠Yes 2□No If Yes, Give 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Athletic Director Education Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Rosina Maroone Julius DeManss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 518 Broad Creek Dr. Stevensville, MD 21666 Rosina Patterson DeManss/Wife 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pegas Department of Important: if it any injury or o 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State Peters Catholic April 29, 2000 Queenstown, MD 4 □ Donation 5 □ Other (Specify) St. 22. Name and Address of Fecility 21. Signature of Funeral Service License Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd. Chester, MD 21619 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician / dedical Immediate Cause (Final disease or condition resulting in death) lelon check Examiner Physician/Medical Examiner sician and buriel-transit The law requires that the deeth cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 68760 ettanding physician for use as the burie that initiated events resulting in death) Last Box P.O. 1 23b. Did tobacco use contribute to the cause of death? ne contributing to death but not resulting in the underlying cause given in Part I. page 2 should be deteched 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 12 8NO 1 Yes 2 No certificata of Vital or Attanding Physicien: 25. Was case referred a 1 Yes DOA Certification: To 2 ERVOut 4□ Nursing Home 5□ Residence 6 □Other (Specify) 다 27. Manney of Death 28d. Describe how injury occurred 28c. Injury at Work? Division After 1 Natural 5 Pending To the Hospital or Attanding within 24 hours effer death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number of Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who comp of death (flem 23a) (Type, Print) BUICE / 32. Registrar's Signature State 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #23aPT1, 2, 5/11/2000, BMW, Montg. Co. Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 27, April 2000 11:55PM Edwin DeLeon /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner | Silver Spring Mon | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | Min. (Month, Day, Year) | MMay 6, 1944 Holy Cross Hospital Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 100 M 2□ F 7. Age (In yrs. lest birthdey) **Funeral** Months 55 Yrs. Washington DC Director 220-42-4643 Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Tes 2 No Director Silver Spring or 28a-f MD Montgomery 10a. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Name 23s 20906 2209 Greenery Funeral Lane 12. Was Decedant Evar in U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 8 1 Yes 20 No 21215-0020 Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Lega Paralegal Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental h Pages 1 and 2 should be Victor Anthony DeLeon Geraldine Davis 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Department of Health at Important: If hem 27 is any injury or other trau 20b. Place of Disposition (Name of cemetary, crematory or other place) Armold COUTING DOVIS
20a. Mathod of Disposition Baltimore, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) Amtomic Gift Foundation 21. Signature of Funeral Service Liced 22. Name and Address of Facility Anatomic Gift Foundation 13948 Baltimor Avenue L Laurl 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock/or heart failura. List only one cause on each line. Approximete tnterval Between Onset and Death **Physician** Immedieta Cause (Final disease or condition resulting in death) /Medical Sepsis Examiner Bacteremia Physician/Medical Examiner The lew requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the burial-trans Due to (or es e consequence of):
Acute Renal Failure
Obstructive Sleep Apnea Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Morbid Obesity Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy High Blood Pressure certificate has Obstructive Sleep Apnea 1 Yes 2 MNO 1 ☐ Yes 2 ☐ No al or Attending Physician: The state death.

I Director: After this certificate of in by the funeral director, ps 25. Was case referred to medicat 26. Placa of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28e. Dete of tnjury (Month, Dey Year) 28c. tnjury et Work? 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier (5) 00052927 4189100 30. Name and address of person who completed causa of daeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Throdorc

31. Date filed (Month, Dey, Year)

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Iguabe 832 Muddy Branch Road Gaithersburg MD 20878

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Catherine **Physician** Daly Joan 2000 0907 April 29 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. (Month, Dilly, Year) OMN 5. Social Security Number 7. Age (In yrs. last bighday) 67 Yrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 218-28-1669 1 M 2 XF Director Aug 29, 1932 Maryland Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits ahow MD Howard Columbia Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 6364 Bright Plume 21044 USA items 23a Funerai death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in an of Health and Mental Hygiene.
Int. If Item 27 Is marked other than "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Catherine Cogswell 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Platzke/ son 6364 Bright Plume, Columbia, MD 21044 Date 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 2000 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 Department of Important: If any injury or 2009. Glen Burnie, MD Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park Funera

that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate the second s ock, or heart failure. List only one Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical almonary hours Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exar Attending Physician: The law requires that the death certificate be are the burta Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown Completed by should be 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy certificate 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 A Natural after deeth. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) ie Hospital or Attanta 24 hours after der me Funeral Director pletely filled in by the 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

Division of Vital Records, P.O. Box 68760,

State Registrar

29a, Certifier (Check only one)

Iroy

29b. Signature and title of certifier

Uckerman, MD 31. Date filed (Month, Day, Year) 32/Registrar's Signature MAY 0 2 2000

-mar mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> 600 N. Wolfe Street

To the Vithin 2

Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

RES-000

Baltimore, mo

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year APRIL 30 2000 10:31 AM Betty Sarah Dellinger 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Days 1 □ M 2 🕃 F Yrs. 577-28-4730 Usual Residence of Decedent March 9, 1908 West Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1807 Brisbane Street 20902 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) GSI Services Cafeteria Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Dellinger Drucilla Andrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (brother-in-law) 807 Brisbane Street James Rutherford, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cometery, cremetory or other plece)
Columbia Furnace Church 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/03/00 Edinburg, Virginia Cemetery of Funeral Service Licens 22. Name and Address of Fecili Francis J. Collins Funeral Home, Inc. an 500 University Blvd., Silver Spring, MD 20901 Approximate fnterval Between Onset and Death

29d. Date signed (Month, Day, Year)

May 1, 2000

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

Funeral

2

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours effer death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show hollory or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burdet-transit completely filled in by the tuneral director, page 2 should be detached for use as the burdet-transit signed by the et d be detached fo

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or o shock, or heart feilure. List o	omplications that caused nly one cause on each lin	the data. Do not enter the re.	node of dying, such as cardia	ac or respiratory arrest,	Approximate fnterval Between Onset and Death							
Immediate Cause (Finel disease or condition resulting in death)	Atheros	clerotic Coron	ary Vascular	Disease								
resulting in death)		Due to (or as a consequence	of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	b. — Due to (or as a consequence of):										
cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	c	cDue to (or es a consequence of):										
	d				1							
Part II. Other significant condition	s contributing to death bu	nt not resulting in the underlying	g cause given in Part I.	23b. Did tobacco use co 1 ☐ Yes 2 ☐ No	ntribute to the cause of death? 3 Probably Unknown							
				24a. Was en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?							
				1 ☐ Yes 2 🕅 No	1 ☐ Yes 2 🛣 No							
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)								
1 Yes 2 XNo	Hospital: 1 ☐ Inpatie	nt 2 X ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)							
27. Menner of Death 1 □{Netural 5 □ Pending 2 □ Accident investigations investigations in the control of the c	ition	y 28b. Time of tnjury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red							
3 Suicide 6 Could no determine		ry - At home, farm, street, fac . (Specify)	28f. Location (Street end Numb City or Town, Stete)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)								
29a. Certifier 1 Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner sta	examination end/or investigat	ed et the time, date and plac ion, in my opinion, death occ	ce, end due to the cause(s) and ma curred at the time, date and place,	anner as stated. and due to the cause(s)							

State Registrar

29b. Signature and title of certifier

Jeanne Asher

31. Date filed (Month, Day, Year)

30. Neme and address of person who completed cause of death (frem 23a) (Type, Print)

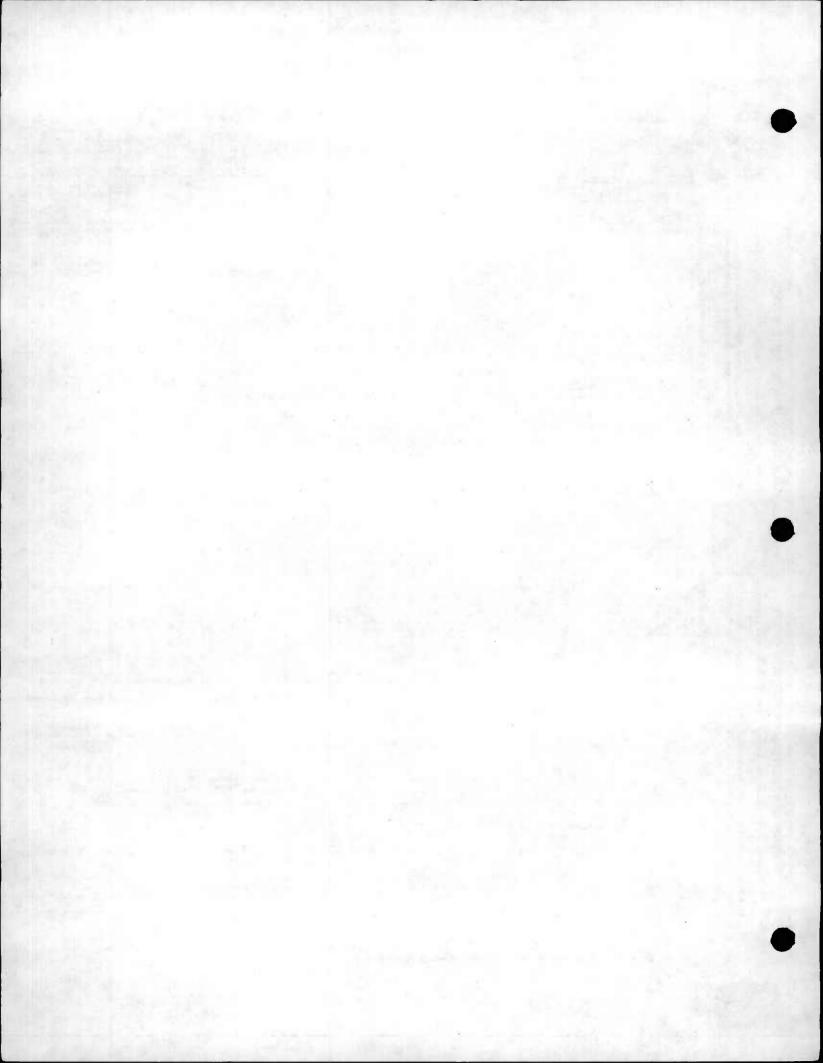
MD

03

Silver Spring, MD Farragut Ave, 32. Registrar's Signature souls

29c. License number

D34032



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Dey 26, 2000 April 12:00 AM Marjorie B. Douglis 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Olney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foraign Country) 6. Sex 1 M 2 X F Yrs. 81 Oct. 10, 1918 New York 092-16-5485 Usual Residence of Decedent 10c. City, Town or Locetion 10d. Inside City Limits 10b. County 1 Yes 200 No Maryland Silver Spring Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?

Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show important: if item 27 is marked other than "natural", or experience must be notitied at once. Baltimore, Maryland 21215-0020

Physician

/Medical

Director

Examiner

Funeral

Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner ate has been signed by the ettending physician end page 2 should be datached for use as the burial-transit To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours effer death.

To the Funeral Director: Affer this certificate has I completely filled in by the funeral director, page 2 a

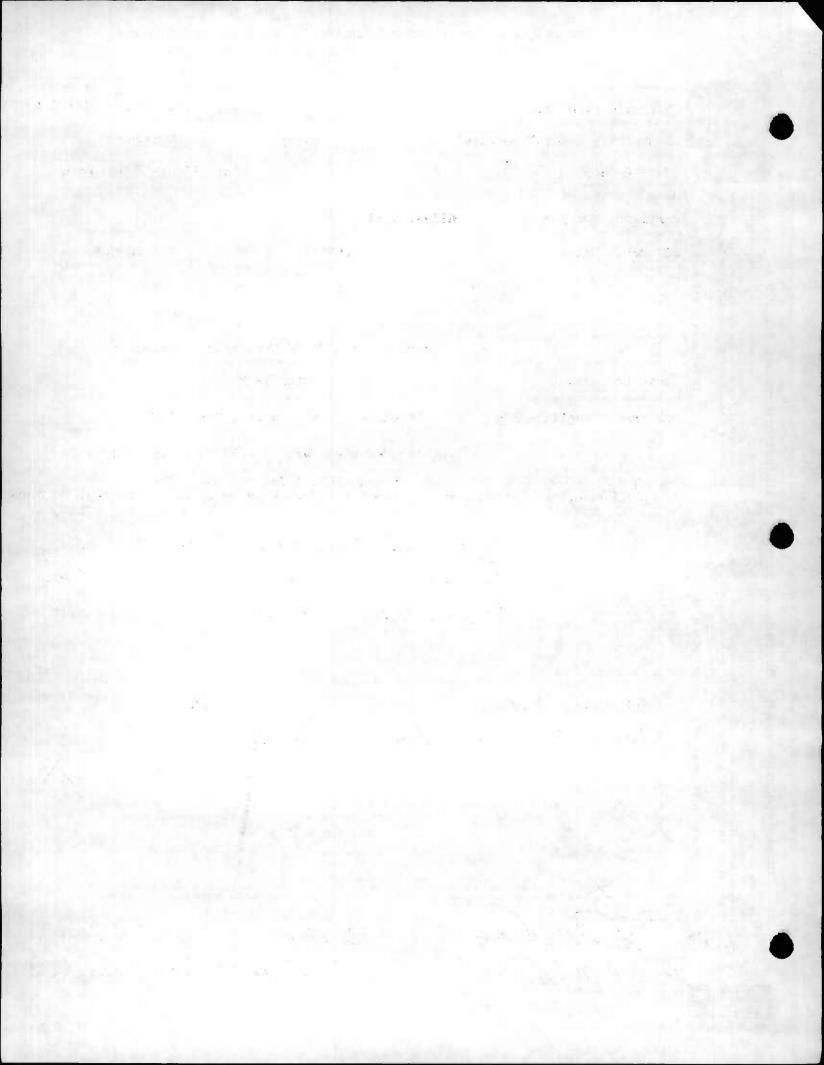
Division of Vital Records, P.O. Box 68760,

804 Hobbs Drive			20904		United States				
11. Maritel Status 1 Naver Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	S. 1	Was Decedent of Hispenic Origin? (S If Yes, specify Cuben, Mexicen, Puer 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Ricen, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Ed		16e De	ecedent's Usuel Occupation		16b. Kind of Bu	usiness/Industry			
(Specify only highest gre	de completed)	(G	ive kind of work done during most of wo le. DO NOT use retired)	rking	Ing				
Elementary/Secondery (0-12)	College (1-4or 5+) 5+		iage and Child Cou		Counco	14na			
17. Fether's Name (First, Middle, Last)		rall.		me (First, Middle,		ounseling			
Louis Bergmann			Ottilie	Fieler					
19a, Informant's Name/Relationship	Time Print)	10b M	lailing Address (Street end Number or R		ar Ciby or Town	State Zin Code)			
						31818, ZIP 3008)			
Dr. Frank Douglis			O West Davis, Conr	oe, Texa		City or Town, Stata			
20a. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, o	cremetory or other plece)			Maryland			
21. Signature of Funeral Service Licer			22. Name end Addrass of Facility	.,00,00	- Landy ,				
	0.1	1	Hines-Rinladi Fune	ral Home	, Inc.				
(orthur)	Dilla		11800 New Hampshir	e Ave.,	Silver	Spring, MD 209			
23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that causad the deati one ceuse on each line.	h. Do not	antar the mode of dying, such as cardia	c or raspiratory ar	rast,	Approximate Interval Between			
	11		1.0 0.1	- U	1	Onset and Death			
Immediate Cause (Final disease or condition	. Hypox	Pm	ic Respirator	a tail	une	1da			
resulting in death)	Pue to 40	r es a con	nsequance of):	1		7			
				•		///			
	(CRO)	300	mic Shack			1 CVC			
-	(aRdi	ore	nic Shock			Iday			
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	· Gastro	inte	stinul Bleed	Pins		I day			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest	· Gastro	inte	enic Shock esequence of): Stinc Bleeck esequence of):	Pins		I day			
(net initieted events	· Gastro	inte	stinul Bleed	Pins		I day			
(net initieted events	· Gastro	inte	stinul Bleed	Ping		I day			
(net initieted events	c. Gastro Due to (o	in te	stinco Bleed sequence of):	7 ns	lobacco use co	/ clay			
resulting in death) Lest	c. Gas Aro Due to (or d	in te	stinco Bleed sequence of):		tobacco use co Yes 2 No	/ clcy. Intribute to the cause of deat 3 Probably 4 Unkno			
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Part II. Other significant conditions of	c. Gastro Due to (or d	In terres a cons	sequence of): ne underlying ceuse given in Part I.	24a. Wes	/	3 Probably 4 Unknot			
resulting in death) Lest	c. Gastro Due to (or d	In terres a cons	sequence of): ne underlying ceuse given in Part I.	24a. Wes	Yes 2□ No en autopsy	3 Probably 4 Unkno			
Part II. Other significant conditions of	c. Gastro Due to (or d	In terres a cons	sequence of): ne underlying ceuse given in Part I.	24a. Wes perfo	Yes 2□ No en autopsy rmed?	3 Probably 4 Unknot			
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Part II. Other significant conditions of the con	c. Gastro Due to (or d	res a consulting in the Law ER/Outpa 28b. Tim Injurome, ferm, wheeled, did	sequence of): Description of the sequence of	24a. Wes performent of the control o	Yes 2 No en autopsy med? Yes 2 No one) dence 8 Ott how injury occur Street end Numb wn, Stete)	3 Probably 4 Unknot 24b. Were eutopsy findings available prior to completion of causa of death? 1 Yes 2 No ner (Specify) rred ber or Rurel Route Number,			
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State Registrar

31. Date filed (Month, Dey, Year)

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 28, April Bernard A. Essex 2000 1015 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1⊠M 2□ F Yrs. 91 June 21,1908 216-46-7777 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Whitingham Drive USA 20904 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Never Married 253 Married 1 ☐ Yes 2 ☑ No Specify: Ves Gi 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemenfary/Secondary (0-12) College (1-4or 5+) Firefighter DC Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Linda F. Schmidt Bernard A. Essex, Sr. 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Whitingham Drive Hester Ryan Essex (wife) Sivler Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 05/01/00 Suitland, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. Keg Skila 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications thef caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . Pneumonia 12 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Obstructive Lung Disease 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1☑ Inpatient 2□ ER/Outpatient 3□ DOA 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show a notified at

"natural", or items 23a or adical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or ther any Injury or other traumetic event, the Medical Examiner

Baltimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records.

Director

Funeral

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Completed

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the Maryland

Examiner Physician/Medical

attending physicien and for use as the burial-transit The lew requires that the death certificete be executed signed by the at d be detached for this certificate hes

þ Completed 8 Certification: To

Medical

 Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifical eleby filled in by the funeral director, To the Hosp within 24 hor To the Fune completely fi

> State Registrar

10

25. Was case referred to medical examiner? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-4 9. make . wo

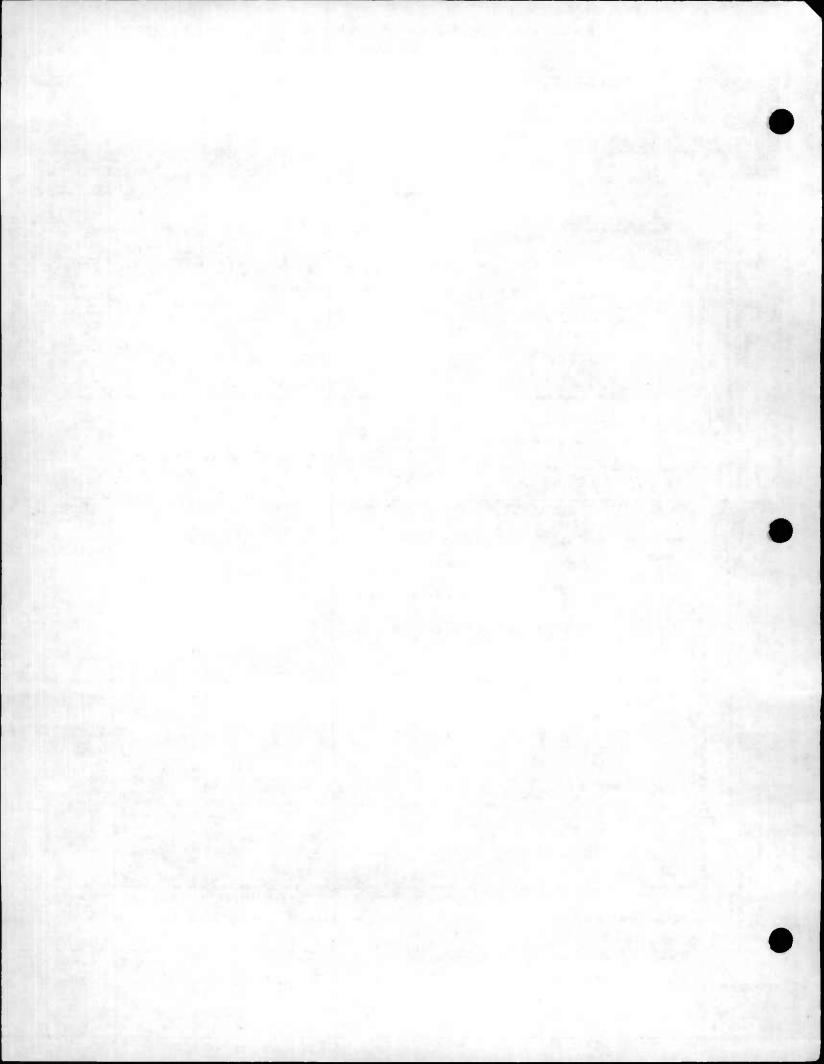
D 23630

April 29,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16220 Frederick Road #213 Gaithersburg, Maryland Frank J. Mayo, M.D.

31. Date filed (Month, Day, Year) 32. Projetrar's Signature MAY 01 souls 2000

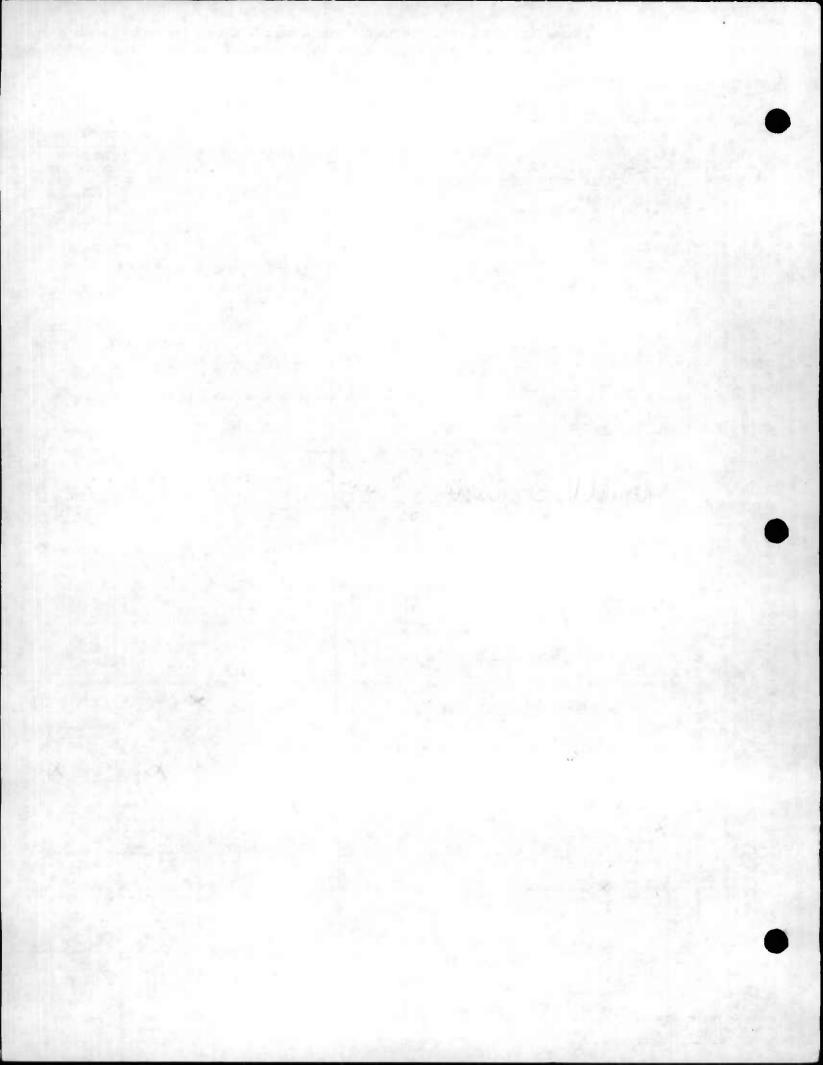


Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15859

			, , and , c	Certificate of		R	eg. No.	1000		
Physician	1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month		3. Time of Deet		
/Medica	rroAd.	0.		Eshenour	ATTEN V	May 3	3, Day 200		•	
Examine					4b. City, Town, o	r Location of Death	4c. County	of Deeth Cgomery		
N	Friends Nur 5. Social Security Number	-	(In use lest high	idev) If Under 1 Year		-		9. Birthplace (Stete or For	roigo	
Funeral Director	172-01-0259 Usual Residence of Decedent	10.30AM 2□ F								
y, Maryland 21215-0020 and 2 should be filed within 72 hours after death with the leasth and Mentel Hygiene. n.27 is marked other than "natural", or items 23 or 28a not traumstic event, the Medical Examinar must be not	10a. State 10b. County	omery		10d. Inside City Limits 1 ☐ Yes 2 % No						
		Road		10f. Zip Code 20832	2	1	10g. Citizen of What Country? United States			
	3 Vidowed 4 □ Divorced	1 Never Married 2 Married 1 Yes. Give				Specify Yas or No- orto Rican, etc.)	No- 14. Raca - American Indian, Black, White, etc. Specify: White			
	15. Decedent (Specify only highes Elementary/Secondery (0-12)	s Education t grade completed) College (1-4or 5+) _ (Decedent's Usual Occur Give kind of work done life. DO NOT use retire Ceman	pation during most of w ed)	orking		siness/Industry S Air Force aint Shop		
	17. Fathar's Neme (First, Middle, I		enour	Caller	18. Mother's N Annie	ame (First, Middle,				
	19a. Informent's Name/Relationsi Lloyd R. Eshene			Mailing Address (Street as #10	t end Number or I	Rural Route Number	r, City or Town,	Stete, Zip Code)		
	20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (Sp.		cemetery	Disposition (Name of cremetory or other place) Cdale Cemet				City or Town, Stata	ania	
	21. Signature of Funaral Sarvice I	Romana	11	22. Name and Addr Donald V. 4400 Powd	ess of Facility Borgwar er Mill	dt Funera Rd. Belts	1 Home,	P.A. Maryland 207	705	
Physician	23a. Part1. Enter the disease, or shock, or heert failure. List	complication that caused the complication that caused the cause on each line	he death. Do no	ot enter the mode of dy	ing, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onsat end Death		
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. myourna Immarian Due to (or as e consequence of):									
P = 5		b	make	TENSMAN						
68760, iicate be axecuted physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	ue to (or as a co							
ox 68760, or certificate be an anding physician use as the buria										
Geath death death death	Part II. Other significant condition	ne contribution to death but	not resulting in	the underlying cause of	iven in Part I	23h Did to	nhacco use cor	tribute to the cause of de	ath?	
that the death ce ed by the attendidetached for use	Empty san		not resulting in	the brideriying cause g	iver in Fart.		23b. Did tobacco use contribute to the cause of death? 1			
I Records, P.O. Box 68760, The law requires that the death certificate be assecuted tale has been signed by the attending physician and page 2 should be detached for use as the burial-transit formulated by Dhystclan Madical Exami						24a. Was a perfor	an autopsy med?	24b. Ware autopsy findin available prior to completion of cause of death?		
The I						1□Y	es 2 No	1 ☐ Yes 2 No		
/ita	25. Was case referred to medical examiner?					eeth (Check only or	10)			
hysic of this of all direction of T.		Hospital:		patient 3L DOA		Home 5 □ Resid				
Division of Vital or Attending Physician: 1 after death. Director: After this certifical Jin by the funeral director, p	27. Manner of Death 1 SNatural 5 Pending 2 Accident invastig 3 Suicide 6 Could n	afion	Year) 28b. Ti	jury We	ork? ☐ Yes 2 ☐ No	28d. Describe h	ow injury occur	∌ ɑ		
DIVISION C tell or Attending P is after death. al Director: After t led in by the funer.	3 Suicide 6 Could n 4 Homicide determi		y - At home, fan <i>(Specify)</i>	m, straet, factory, office		28f. Location (S City or Tow		er or Rurel Route Number,		
ne Hospi n 24 hou ne Funer pletsly fill	29a. Certifier Certifying (Check only one)	Physician: To the best of examiner: On the basis of e and manner state	xamination and	death occurred at the t for investigation, in my	ime, date and pla opinion, death oc	ca, and due to the c curred at the time, c	euse(s) and me late and place, a	nner as steted. and due to the cause(s)		
To the comp	29b. Signatura and fitle of certifier	11.			ise number	2	29d. Date signed	(Month, Dey, Year)		
20	En	1 glu		V	25947		May 3,	2000		
	30. Name and address of persor Evelyn D. Jacks				larksvi]	le, Mary	land 210)29		
State Registrar		2000 32 Registrar	-	. Spork	'					

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		Certificate of Death										- Ivieritai i i	Reg. No.					
	Physician	1. Decedant's Nama (First, Middle, Last)									2. Date of D Month	aath Day	Yaar	3. Tima of Dea	ath			
	/Medical	ı	Annette	Franze	1							April	25, 200	00	23:25			
1	Examiner	4	a Facility Nama (If not Institution, g	iva straat and	number)					4b. City, Town, or	Location of Daa						
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			Montgome Social Security N		Sax		L a (In yrs. la:	st birthday)	If Under	1 Year	Olney If Under 24 Hr	s. 8. Data of B				raion		
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020 urs after d	I 21215-0020 ed within 72 hours after death with the Menyland sygiene. The Tratural, or Items 23a or 28a-f show it, the Medical Examine must be norified at Completed by Funeral Director			ried 2 Married	1 ☐ Ye	s 2 Th			if Yas, spec 1 □ Yas 2		lispanic Origin? (an, Maxican, Pua Specify:	rto Rican, atc.)	Special Special	ck, Whita,				
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State of Maryland / Department of Health and Mental Hygiene

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State Registrar 31. Data filad (Month, Day, Year) MAY 01 2000

32. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middla, Last) 3. Time of Deeth Dey **Physician** 28, 2000 April 1:35 am Ana Maria Fernandez /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. Director 577-68-0031 April 6, 1926 Spain Usuel Residence of Decedent daath with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filled within 72 hours aftar death with the Maryla Department of Health and Mantal Hygiena. Infrontant: If item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Modical Exerther must be notified at page. 1 ☐ Yes 2 No Directo Maryland | Montgomery Silver Spring 10g. Citizen of Whet Country? 10e. Street end Number USA 3810 Bel Pre Road #5 20906 Funeral 12. Was Decedent Ever In U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 1 ☐ Never Married 2 Married Yas 2 No Specify: Spanish Baltimore, Maryland 21215-0020 ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Surnama) Be 2 Isidora Diaz Idelfonso Blanco 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Felix B. Fernandez (husband) 3810 Bel Pre Road #5 Silver Spring, Maryland 20906 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burlal 2 ☐ Cramation 3 ☐ Ramovel from Stete 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 05/01/00Silver Spring, Maryland 21. Signeture of Funeral Service Licenses 22. Neme end Address of Facility Francis J. Collins Funeral Home, Inc. Kein Stule 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician Immediate Ceuse (Final disease or condition resulting in death) 20175 /Medical pre-moria Examiner Dua to (or es a consequence of): Examiner The law requires that the death certificate be axecuted attanding physician and for usa as tha burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury Dua to (or es e consequence of): P.O. Box 68760, Physician/Medical that initieted events resulting in deeth) Lest Due to (or as a consequence of): signed by the a Pert il. Other significant conditions contributing to deeth but not resulting in the undarlying ceuse given in Pert i. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Adenosissi Numo of Liver Records, by 24b. Were eutopsy findings evailable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed nis cartificata has b I director, paga 2 s 2 PNo 1 Yas 2 No 1 Yes Division of Vital or Attending Physicien: Be 25. Wes cese referred to medicel 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Aftar 1 Netural 5 Pending investigation hours after death. uneral Director: Af ely filled in by the fi daath. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Spacify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dil completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as steled.

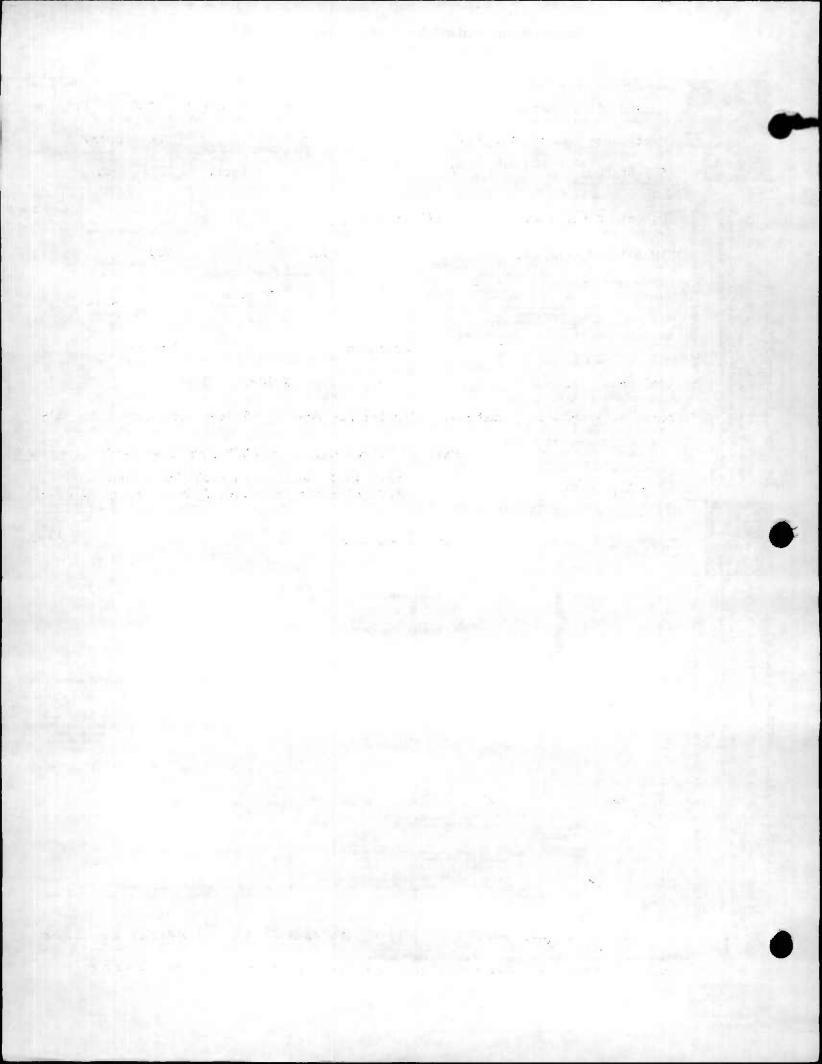
2 Medical Examinar: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steled. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number I man , ma 023630 APRIL 28, 2000 15 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Fronk J. MAYO, MP 16220 Frederick RA #213, 6. theriburg, MA 20877

State Regist<u>rar</u> 31. Date filed (Month, Day, Year)

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32. Registrar's Signeture

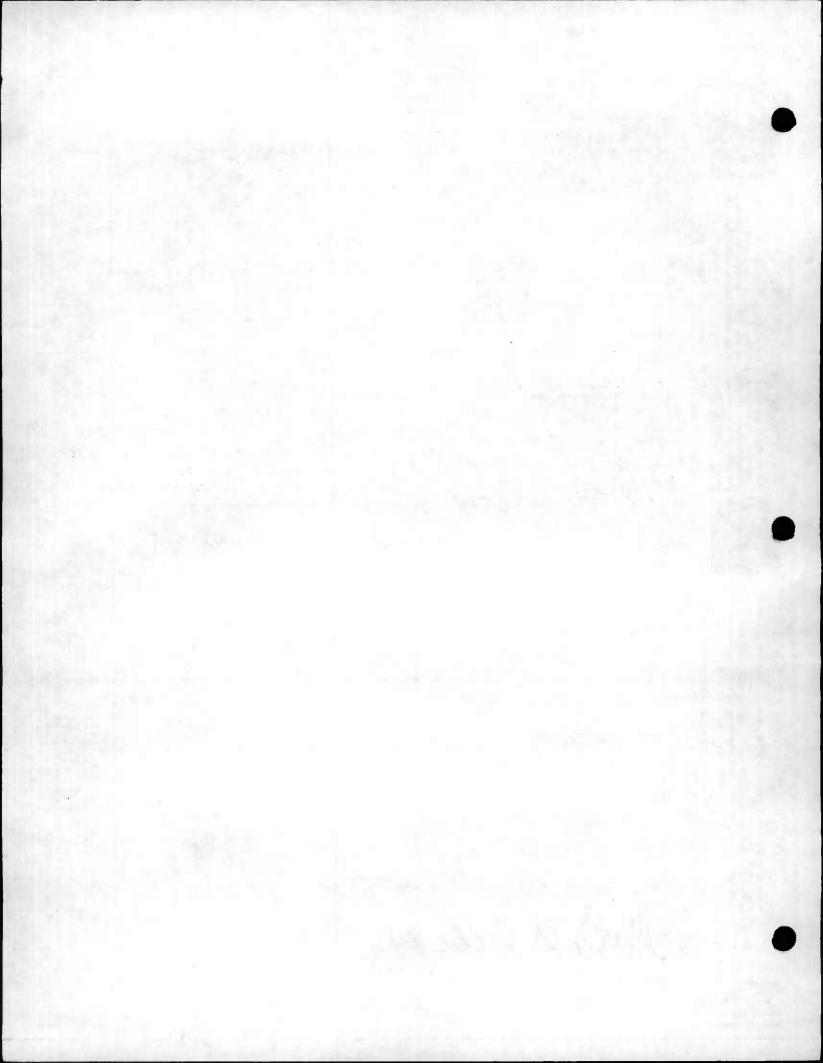
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Physician /Medical	BRUCE FELI	MAN					Month 04	Day 28	2000 2:48pm		
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thems 23s or 28s-f show filer must be notified at furneral Director	10a. Street and Number 7 Rosebay ct.			10f. Zip (087	6		10g. Citizen of W			
r. or the	1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Detes:	ar in U,S. 13.	Was Decede If Yes, speci 1 Yes 2		lispanic Origin? (Sp an, Mexicen, Puerto Specify:	ecity Yes or No Ricen, etc.)		14. Race - Amaricen Indian, Bleck, White, etc. Specify: White		
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	17. Fether's Name (First, Middle, Last)	2	TI CO.	lages		18. Mother's Nem	me (First, Middle, Maiden Surneme)				
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and can saith and n 27 is m er traum	Estelle Fe					end Number or Rur rk DR. Gr					
- £ 5 6	20a. Method of Disposition		20b. Place of Disp	osition (Nam	e of		Date		City or Town, State		
0 = 0 V2	1 ☐ Burial 2 ☐ Cremation 3 ☒R 4 ☐ Donation 5 ☐ Other (Speedy)	lemoval from State					04-30	-2000 Ea	lls church V		
Department importants any injury price.	21. Signature of Funeral Sarvice Licensee 22. Name end Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYI										
	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	ications that ceused the cause on each line.							Approximete Interval Between		
hysician /Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	Acute Re	enal Fail	ure				12	Onset and Death		
je je	Due to (or as e consequence of):										
physician and street transit to burial-transit edical Examiner											
g physician and as the burial-transit	Cause (Disease or injury that initieted events resulting in death) Last	Du-	e to (or as a conse	quence of):							
e attendir of for use		l									
d by the attendinesched for use	Part II. Other significant conditions con	23b. Did tobacco use contributs to the caus									
een signe hould be d							24a. Was	an autopsy ormed?	24b. Were autopsy finding evallable prior to completion of cause		
ate has beage 2 s							10	Yes 2↓No	of death? 1 ☐ Yas 2 ☐ No		
this certificate has bird director, page 2 s	25. Was casa referred to medical examiner? 1 Yes 2 No	lospital:	2 ER/Outpatie	nt 3 DO/	Oth	26. Plece of Deat er: 4 ☐ Nursing Ho		dence 6 Othe	ar (Specify) HOSPICE		
r death. sctor: After thi by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation	28e. Date of Injury (Month, Dey Y	(ear) 28b. Time of Injury	M 28	c. Injur Wor	y et k? Yes 2 □ No	28d. Describe	how injury occurr			
1 5 F	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homlcide detarmined	28e. Plece of Injury building, etc. (- At home, farm, st Specify)	reel, factory,	office		28f. Location (City or To		er or Rural Route Number,		
within 24 hours To the Funeral I completaly filled Medical Ce	29a. Certifier Cortifying Phys	icien: To the best of n	amination and/or in	h occurred a vestigation,	t the tin	ne, date and plece, pinion, death occur	end due to the red at the time,	cause(s) end ma date end place, a	nner as stated. and due to the cause(s)		
within 2 To the comple	29b. Signature and title of carifler 29d. Date signed (Mc										
1	May Q	M. Obd	Oc for		0376	620		APRIL 29	9, 2000		
13	30. Narae/and address of person who co					ASTED MIT.	T. RD E	OCKVIT.I.F	E, MD 20855		
	31. Date filed (Month, Dey, Year)	32. Registrar's		Ina							

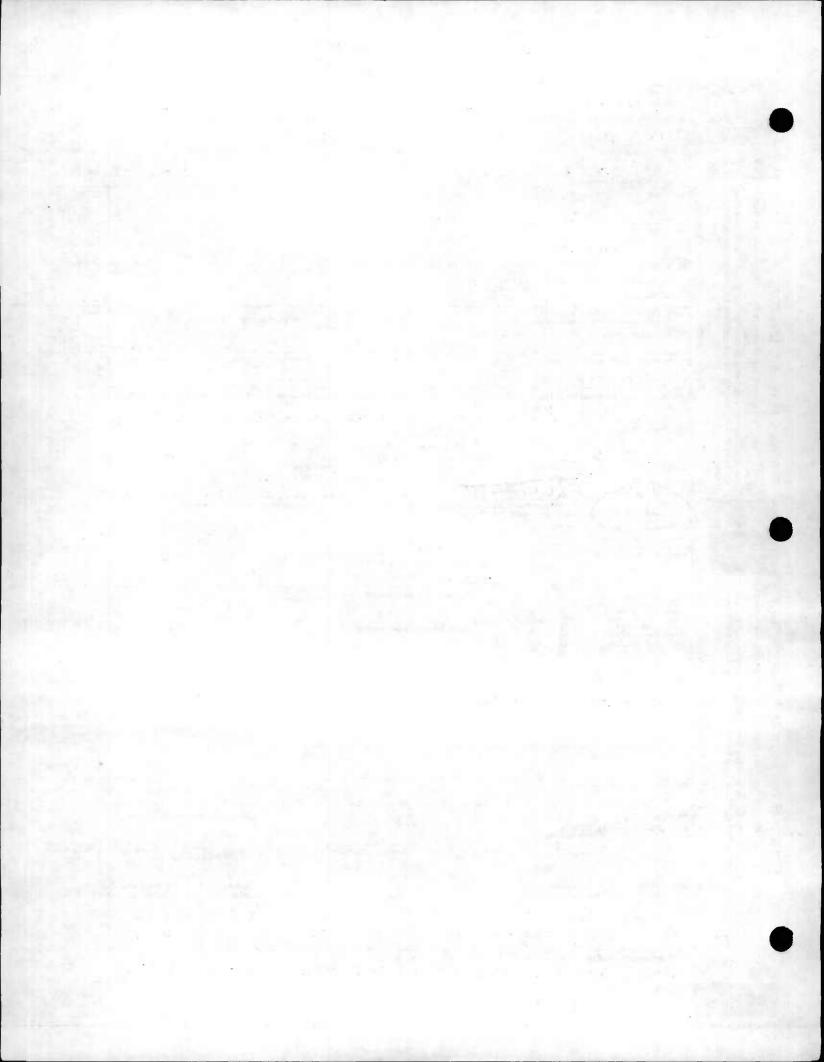
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State of Maryland / Department of Health and Mental Hygiene 15864

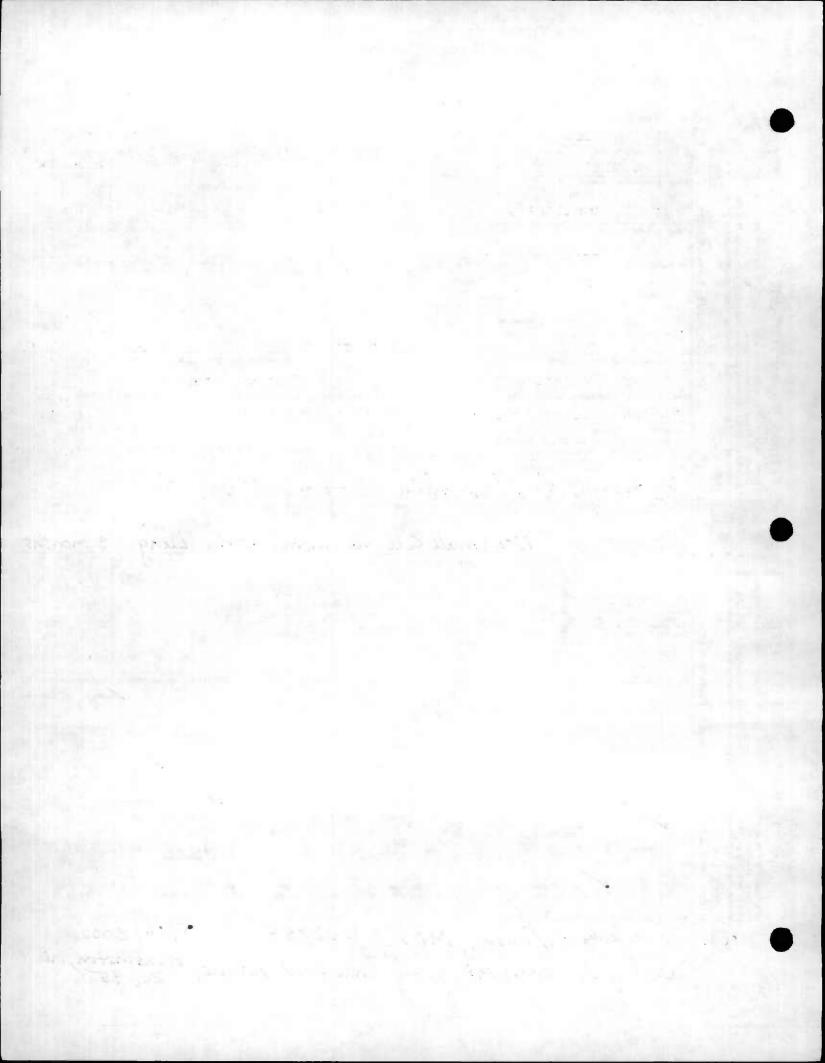
				Certific	ate of	Death		Reg. No.				
	1. Decedent's Name (First, Middle, La	ast)					2. Dete of D		Yeer	3. Time of Deeth		
Physician /Medical	Mary Ann Davelin	e Federline	9					30, 2000		0515		
Examiner	4a Facility Name (If not institution, gir	ve street and number)				4b. City, Town	, or Location of Dec	eth 4c. County	of Deeth			
78	13730 Notley Road					Silver		Montgo				
Funeral Director	218 20 2432	4DM aMe	(In yrs. last bii 72	Yrs. If Un Monti	der 1 Year ns Days		Min. (Month, I	Dey, Year)		plece (State or Foreign ntry) .ngton,DC		
2	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits		
vith the Maryt or 28a-f sho be notified at Director		nery	Silver	Spring				ī		1 ☐ Yes 2 ☐ No		
ar death with the Maryla Herra 23e or 28e-f sho ner must be notified at 'uneral Director	10e. Street and Number 13730 Notley Road	i		100	Zip Code 904			10g. Citizen of USA	Whet Cour	alry?		
		12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			cedent of I pecify Cub 2 ☑ No		n? (Specify Yes or I Puerto Ricen, etc.)	No- 14. Rac Blac Specifi	cen Indien, etc. nite			
d 2 should be filed within 72 hours at the and Mental Hygiene. 7 is marked other than "natural", or traumetic event, the Medical Examp To Be Completed by F	15. Decedent's E	ducation	16a	Decedent's U	suel Occu	pation		16b. Kind of B				
sed within 7 typiene. Ner then 'n nt. the Med	(Specify only highest gr. Elementary/Secondary (0-12) 1 2	College (1-4or 5- 2	life. DO NO		during most o	r working	Home Bu	ilde:	rs			
田工物品 典	17. Fether's Name (First, Middle, Last	")				18. Mother's	Neme (First, Midd			- 0		
Mental Parked of	David O. Seek			Ann Taylor								
W M. M.	19a. Informant's Neme/Relationship	(Type Print)	19h	Meiling Addr	ass (Street	1		Rural Route Number, City or Town, Stete, Zip Code)				
Pages 1 an nent of Heat uny or other	Cheryl A. Federli 20a. Method of Disposition 1 Burial 2 Cremetion 3 D 4 Donation 5 Other (Specia	Removel from State	20b. Piece of comete. George	1931 Bronzegate Boulevard, Silver Spring, MD ace of Disposition (Neme of place) rege Washington Cemetery Date May 3, May 3, Cemetery Adelphi, Maryl						own, Stete		
Departs Departs Imports any Inju	21. Signature of Fureral Service Users of Fureral Home Hines-Rinaldi Funeral Home 11800 New Hampshire Ave., Silver S											
Physician	23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused pne cause on each line	the death. Do	not enter the n	node of dyi	ing, such es ca	rdiac or respiretory	errest,	Spin	Approximete Intervel Between Onset end Death		
/Medical	Immediate Cause (Finel disease or condition	1	2 yr									
Examiner	resulting in death)	a	Due to (or es e	consequence	of):							
D = C	MIRROR DE LA COMPANION DE LA C	. Emphy	ysema						i	7 yr		
ficate be executed physician and is the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	Due to (or es e	consequence								
£ 5 5	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or es e d	consequence	of):	M.						
death of for use siciar	Part II. Other significant conditions of	contribution to death bur	t not reculting in	a the underhein	a coura ai	von in Bort I	22h Di	d tobacco use co	ntribute t	o the cause of death?		
t pp	gastrointestina					bably 4 Unknown						
aw requir				es en eutopsy formed?	ev	fere autopsy findings relieble prior to empletion of cause death?						
The law ate has page 2							10	Yes 2 No	1[Yes 2 No		
certificate rector, pag	25. Wes cese referred to medical					26. Place of	Deeth (Check only	one)				
Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Ou	tpatient 3	DOA OI	hor	ng Home 512 Re		ner (Specit	fv)		
£ £ #	27. Manner of Death 1 Shetural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day		Firme of njury	28c. Inju Wo		28d. Describ	e how injury occur		,,		
To the Hospital or Attending P Within 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	ry - At home, fe (Specify)	rm, street, fec	tory, office		28f. Location City or T	(Street end Numi own, Stete)	ber or Rure	el Route Number,		
To the Hospital within 24 hours a To the Funeral E completely filled Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 20a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.											
Withir To the comp	29b. Signature and title of certifier	d (Month,	Dey, Year)									
10	5-6.9.	w . w	P		D23	3630	DOM:	May 2,	200	0		
14 174	30. Name and address of person who Frank J. Mayo, M.				d, #2	13, Ga:	ithersbur	g, Maryl	and	20877		
State	31. Date filed (Month, Day, Year)		r's Signeture	4 1	-	,						



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State of Maryland / Department of Health and Mental Hygien | 5865

		Certificate of Death Reg. No.												
		1. Decedent's Nama (First, Middle, Last)				2. Data of Deat		3. Tima of Death					
	Physician	JERRY	J. (MAY 3,	2000	8:06 PM							
1	/Medical Examiner	4a Facility Nama (If not institution, give		GAITHER	, JR	4b. City, Town, or	Location of Death	4c. County of						
	LAGITIMICI	2411 Lyttons	ville Rd.	, #204		Silver			GOMERY					
	Funeral Director	219-46-7114	7. Age (li	n yrs. last birthday) 2 Yrs.	Months Days	If Undar 24 Hrs Hours Min	8. Date of Birth (Month, Day, NOV • 2	, 1947	9. Birthplace (State or Foreign Country) Wash. DC					
	b *	Usual Residence of Decedent 10s. Stata 10b. County	10	Dc. City, Town or Lo	ncation				10d. Insida City Limits					
	vith the Maryi or 28a-f eho be notified Director	MD Montgo			ver Spr	ing		1⊠ Yas 2(
	ter death v terms 23s per ment	10e. Street and Number 2411 Lyttonsv	ille Road		10f. Zip Code 209	10	1	0g. Citizen of WI						
21215-0020		11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1√2 Yes 2 ☐ No If Yes, Give Year or Dates:	r in U,S. 13.		Hispanic Origin? (S an, Mexican, Pua	Specify Yas or No- rto Rican, etc.)	or No- 14. Race - Amarican India						
5		15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usuel Occur kind of work done	pation	ndkina	16b. Kind of Bus	iness/Industry					
7	uthin de	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	nkiig							
	771	12th		В	us Driv	er		Montg	. Co.Ride-Or					
D	EISE -	17. Father's Nama (First, Middle, Last)				18. Mothar's Na	ma (First, Middle, A	ma (First, Middle, Maiden Sumame)						
<u>a</u>	merked of	Jerry J. Gai	ther, Sr.			Thel	ma Gran							
Maryland	2 sho and is ma	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailir	ng Addrass (Street	t and Number or R	lural Route Number	City or Town, S	Stete, Zip Code) 20910					
Σ	Health Health Jem 27	Thelma Gaither	(Mother)	241	1 Lytto	nsville	Rd., S	ilver	Spring, MD					
Baitimore,	permit. Pages 1 and 2.st Department of Health and Important: if item 27 is n any injury or other treum ancs.	20a. Method of Disposition 1 Deta 20c. Location - City of Cermeton 5 Other (Specify) 20b. Place of Disposition (Name of Cermetory or other place) Cate of Heaven Cem. 5/9/00 Silver												
a	Departm Departm Importar any Injur		21. Signature of Funeral Service Licensee 22. Nama and Address of Facility SNOWDEN FUNERAL HOME, P.A.											
m	82E28	Roma K	Ma	well		LLE, ME		, P.A.						
		23a. Part1. Enter the disease, or composhock, or heart feitura. List only of	ications that caused the	deeth. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arre	ast,	Approximata					
N.	Physician	snock, or neart regura. List only o	ne cause on each line.						Onsat and Death					
1	/Medical	Immediata Causa (Final	Alon Con	all Call	1 Carre		- 14	1,000	= no months					
	Examiner	disease or condition resulting in death)	a. TUVN SM	au cell	, carci	noma	of the	Lung	5 months					
	<u> </u>	Due to (or as a consequence of):												
	ficate be executed physician and is the burial-transit edical Examiner	b. Due to (or se a consequence of):												
_	entificate be executed ling physician and es the burial-transit	Sequentially list conditions, if any, leading to immediate it any, leading to immediate cause. Enter linderlying												
68760,	siciar buri	ceuse. Enter Underlying Cause (Disease or injury that initiated events												
28/	phys the	that initiated events												
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20	for u													
o.	at the deeth c d by the attend stached for us Physician	Part II. Other significant conditions co	ntributing to death but n	23b. Dld to	bacco use cont	ributa to the cause of death?								
1,	es that the deeth or igned by the attend be detached for us by Physician.		1 🗆 Ye	98 2□ No :	3 Probably 4 Unknown									
Hecords,	nequin						24a. Was a perform		24b. Wera autopsy findings available prior to complation of causa of death?					
	The law ate has the page 2 a Compile	The second					1 □ Ye	s 200 No	1 Yas 2 No					
0	certificate rector, peg	25. Was casa refarred to medical			-	26 Place of Do	eath (Check only on		10100					
VITAI	Physicien: this certific ral director,	examiner?	lospital:	2 ER/Outpatier	nt 3 DOA Ot	hor	Home 5 Reside		/Consibil					
o uc	Mar this uneral di	27. Mannar of Death 1 12 Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Ye	28b. Tima of	28c. Inju	ry at ork?	28d. Dascribe ho							
Division of	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, atc. (5	Yas 2 No	28f. Location (St City or Town		r or Rural Route Number,							
	To the Hospital of within 24 hours all to the Funeral D completely filled I wedical Ce	29a. Certifier 1 Certifying Phys	sician: To the best of m	y knowledge, deeth	occurred at the ti	me, date end plec	e, end due to the ca	ause(s) and man	nar es stated.					
	n 24 n 24 n 24 plete	29a. Certifier (Check only only only only only only only only												
	Within To the comp													
	12	Weely &	Mason	MA	DZ	2235		141	2000					
	10	30. Nama and address of person who co	ompleted cause of death	(Item 23a) (Type.	Print)			4000	into MD					
		1 'A A .	250h, MD	. 10810	Connec	ficut 1	Avenue	Trous C	95					
	State	31. Data filed (Month, Day, Year)	32. Registrar's	Signatura 🛕)	200	10					
	Penistrar	MAY 05 20	nn Dener		Anna K	1								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Delma Gillespie 5:38 AM April 28, /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 30, 1916 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foreign **Funeral** Months Days Min 1 M 2 □ F 460-01-8054 84 Yrs. Texas Director Usuat Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Llmits 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at MD 1 Yes 2 No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20817 9504 Milstead Drive USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mertal Hyglene.
Important: If flem 27 ie marked other than "natural", or then eny linjury or other traumatic event, the Medical Example DOCS. Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Lab Research Technician Oil and Gas 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be William Clyde Shellie Rollen 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 9504 Milstead Drive Bethesda, MD Lawrence Gillespie (Son) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Forest Park Lawndale Cem. 05/01/00 Houston, Texas 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Addrass of Facility
Capitol Funeral Service, Inc. 7211 Lee Hwy Falls Church, VA 22046 23a. Part. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** Immediata Cause (Final disease or condition rasulting in death) /Medical hours Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit The lew requires that the deeth certificate be executed Sequentially tist conditions, if eny, teading to immediate cause. Enter Underlying Cause (Dissass or injury that initiated events resulting in death) Last Due to (or as e consequence of): 1122016 0538 Am. tal Records, P.O. Box 68760, Due to (or es e consequence of) cate has been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings evailable prior to completion of cause of daath? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Vital Attending Physician: funarel director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yes 25 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA on of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Panding 1 Yes 2 No hours after death. investigation Divisi Director: 6 Could not be To the Hospital or Atte within 24 hours after de To the Funerel Directo completaly filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier Dertifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to tha causa(s) and mannar as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 06019 ln 0 Kluner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WISCENSIN AVE CHENY CHASE MD 20815 KENNER M 5454 ARRIS

DHMH 16 Rev 6/95

State

Registrar

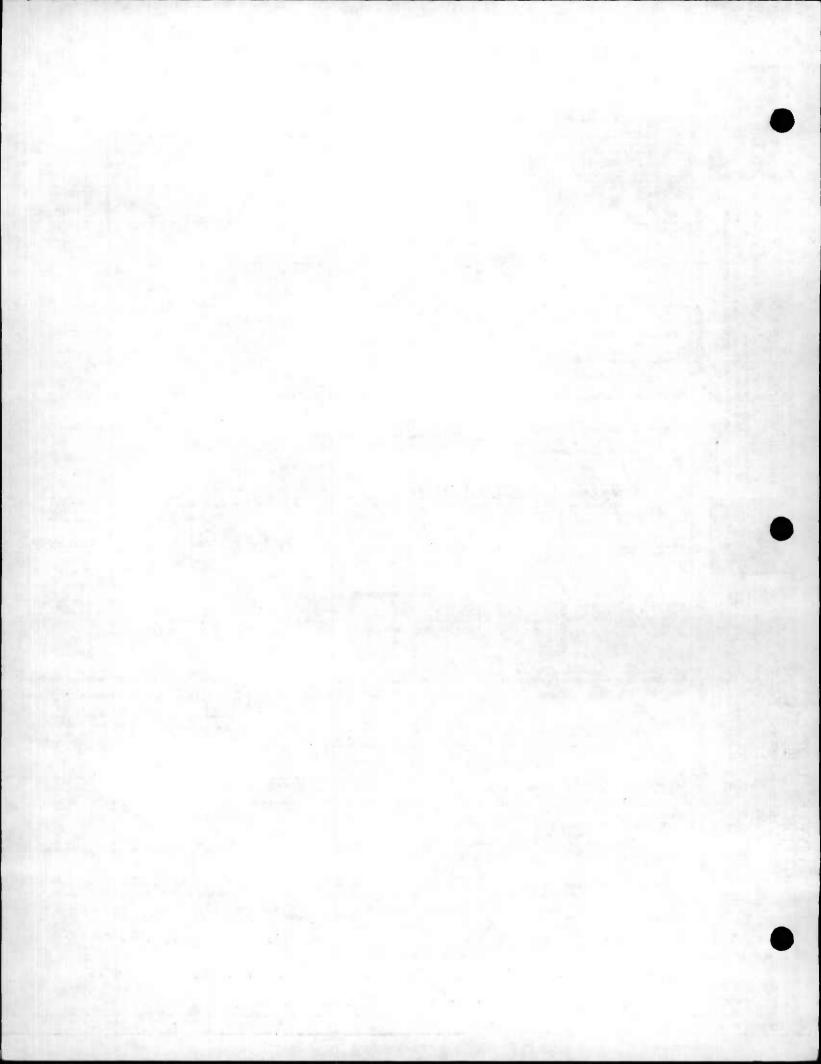
31. Date filed (Month, Dey, Year)

03

2000

souls

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Dey Month KATHERINE GOTARD MAY 2 2000 5:23 PM 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BROOKE GROVE NURSING HOME SANDY SPRING MONTGOMERY 5. Sociel Security Number if Under 1 Yeer if Under 24 Hrs. Birthplece (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 10 M 20 F Months Days Hours 233 03 1847 Yrs. 90 MARCH 11,1910 OHIO Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. MONTGOMERY ROCKVILLE 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5700 BIRCHWOOD COURT 20855 UNITED STATES Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Americen Indien, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3. Widowed 4 □ Divorced WHITE Yeer or Dates: 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CHARLES POUL TON ANNA LETZELTER 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CATHERINE ANNE SCHMOLL, DAUGHTER 5700 BIRCHWOOD COURT, ROCKVILLE, MD. 20855 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Locetion - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 5/5/00 SILVER SPRING, MD. 21. Signature of Funerel Service Licensee MURIEL H. BARBER FUNERAL HOME BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel SWEEKS MEUMONIA disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown MULTIPLE CEREISPAL 24e. Was en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 1 Naturel 2 Accident 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

à

Completed

Be

P

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 28e or 28e-4 show any injury or other traumetic event, it is Medical Examina.

Maryland 21215-0020

Baltimore,

the attending physician and thed for use as the burial-transit signed by the at Id be detached for this cartificata Aftar death. after death Director:

Hospital or Attanding Physician: The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medical ò Be Completed 2 Certification: in by the

within 24 hours aft To the Funeral Di completely filled in

29b. Signature and title of certifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1300N9130120, 7542 OVERLOOK DR ED E. Howe

investigation

2000

MAY 04

6 Could not be determined

3 Suicide

29a. Certifier

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

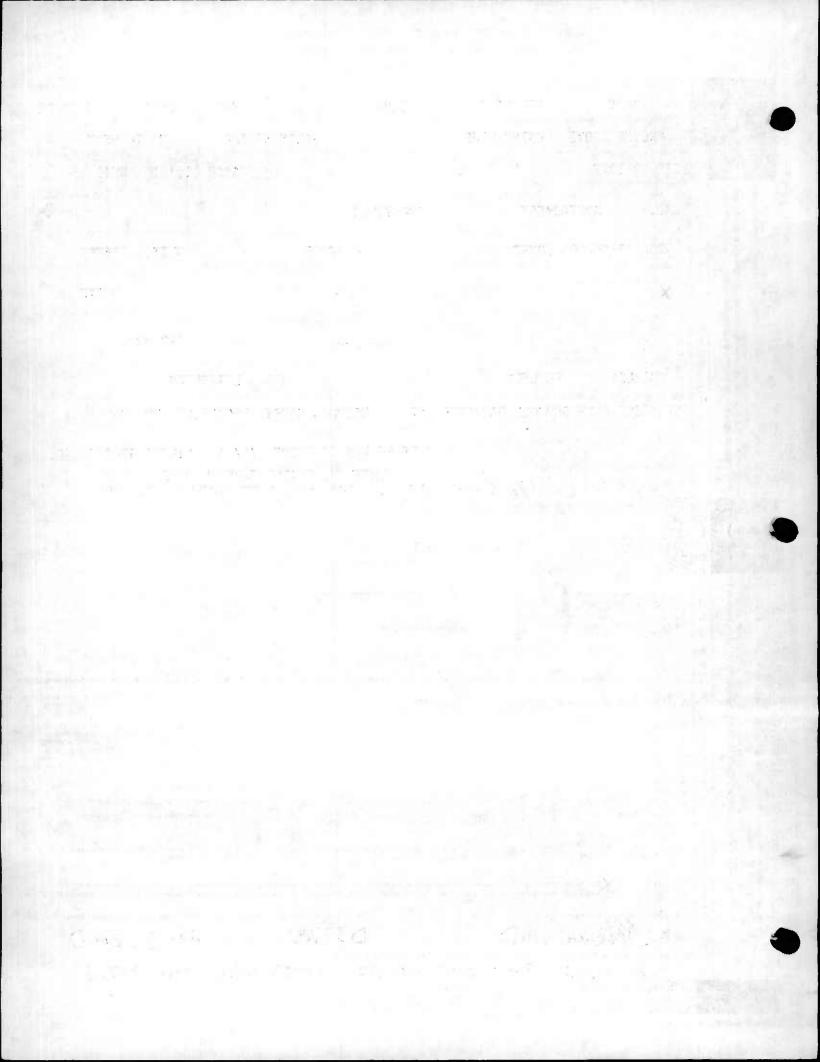
1 ☐ Yes 2 ☐ No

32. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Dete filed (Month, Dey, Year) State Registrar

Medicai



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** HART MABEL April 25 2000 2332 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foraign Country) **Funeral** Days 1□ M 2⊠ F 93 Director 035-42-1768 July 5, 1906 England Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s-1 show any in lury or other traumatic avant, the Medical Examinar mark to notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20876 by Funeral 19104 St. Johnsbury Lane United States 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Meritel Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 3aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. 3XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Richard Hollings Miriam Wright 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Irene Grady (Daughter) 19104 St. Johnsbury Lane, Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, State Date 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4/29/00 Highland Memorial Park Johnson, Rhode Island 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive 21. Signature of Funerel Service Licenses obert Gaithersburg, MD 20877 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximeta Interval Batween Onset and Daath Physician PNEUMOPERIFORIUM Due to (or es a consequence of): Ruptuse Of Intestine Due to (or es a consequence of): Immediata Cause (Final diseesa or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner physician and s the buriai-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Due to (or as a consequence of): USB 28 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should be det Completed by 24b. Were eutopsy findings availabla prior to complation of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No certificata 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 (Natural 5 Pending 1 TYes 2 TNo investigetion 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Records, Division of Vital death. 24 hours after deat Funeral Diractor: 2 filled in Hospital To the Hosp within 24 ho. To the Fune completely fi

Medical

State

Registrar

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Ramleth T. Shakir, MD, 9019 Shady Grove Court, Gaithersburg, MD 20877 31. Dete filed (Month, Day, Year)

2000

MAY 01

Shaku

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signeture

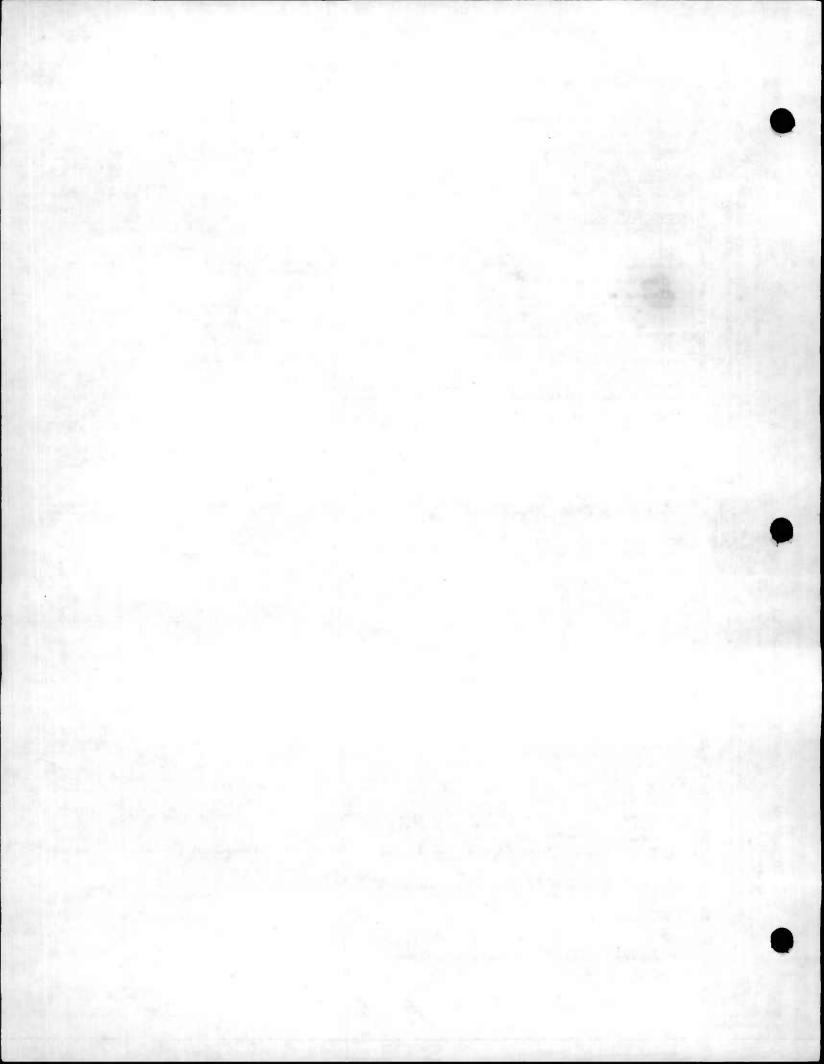
1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the ceuse(s) end menner steted.

29c. License number

D 27830

29d. Date signed (Month, Dey, Year)

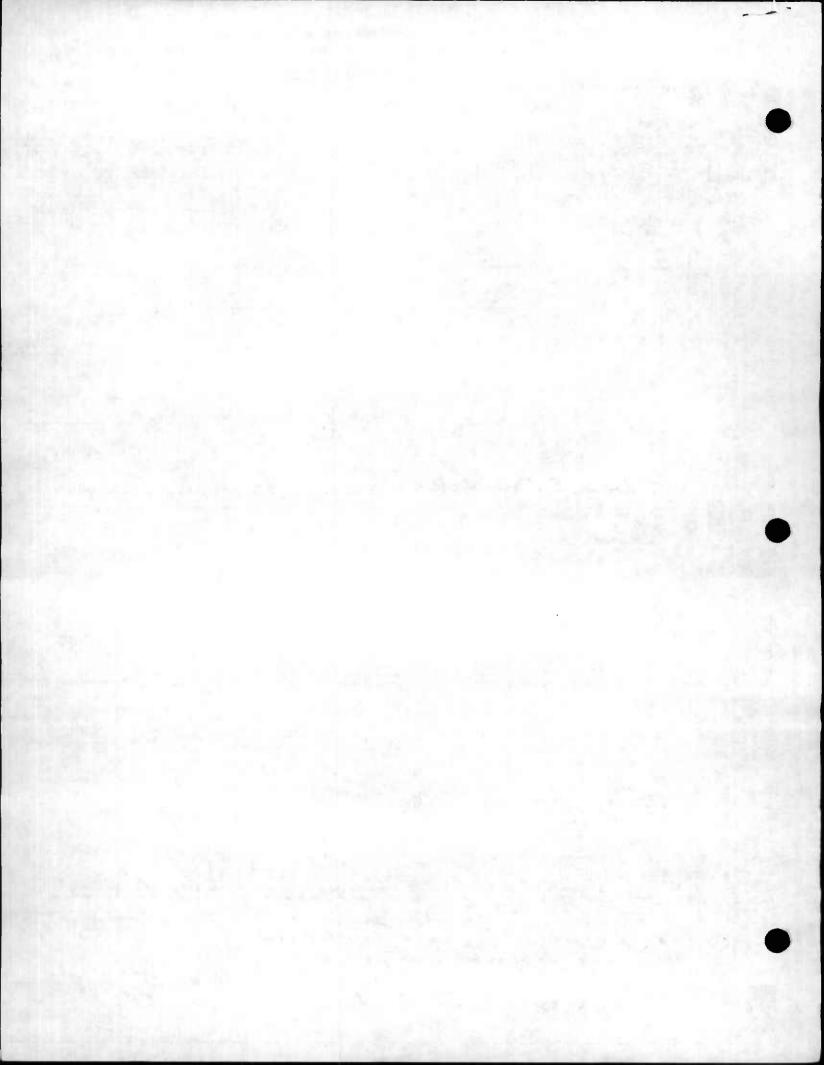


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		Certificate of Death Reg. No.										1002		
	Physician	Decedent's Nema (First, Middle, Last) Data of Death Month Day Yaar												
	/Medical	Charles	В.		ey, Jr					il 28, 2000 2:30 PM.				
	Examiner	4a Facility Nama (If not institutio		umber)			4b. City, To	wn, or Locatio	n of Death	4c. County of	of Death			
_		3609 Cardiff		T =		I Williadas & Visas		Chase		Montg				
п	Funeral	5. Social Security Number	6. Sex 12 M 2□ F		. last birthday) Yrs.	Months Days		Min.	Data of Birth Month, Dey, 1	reer)	9. Birth	placa (Stata or Foraign ntry)		
	Director	181-16-3133 Usuat Rasidence of Decedant		79	110.			Dc.	t. 15,	1920 I	enn:	sylvania		
	pue &	10a. Stata 10b. County 10c. City, Town or Location										10d. Inside City Limits		
	Aaryl r sho					100						1 ☐ Yas 2 No		
	the N	Maryland Montg	omery			10f. Zip Code	Chase		100	. Citizan of W	That Cou	ntry?		
	with with					101. 249 0000								
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	her d	11. Manital Status 12. Was Decedent Evar in U,S. Armed Forces? 1 Never Married 2 Married 1 Mar							n, atc.)		k, Whita,			
020	of, or	3 ☑ Widowed 4 □ Divorced Yaar or Datas: ₩₩II								Specify:	Whi	te		
9	filed within 72 hours after deeth with the Maryland Hygiene. Hygiene natural', or flame 23a or 28a-f show ant, the Marical Examinat must be notified at e Completed by Funeral Director	15. Deceder	nt's Education		16e. Dece	dent's Usual Occup	pation		16	16b. Kind of Business/Industry				
215	pie pie	(Specify only highs Elementary/Secondary (0-12)	st grada complated) (1-4or 5+)	(Giva	kind of work dona DO NOT use retire	during most d)	of working						
21215-0020	d wild	Unknown	Unknow		Real	Estate Br	roker/	Engin	eer	Real :	Esta	te		
p	be file d othe event,	17. Father's Nama (First, Middla,	Last)				18. Motha	r's Nama (Fir	st, Middla, Ma	idan Sumama	a)			
lai	Menta Menta Menta Tro B	Charles Burrid	ge Hawlev	1			A	ntoine	tte Wr	ight				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marylan Examiner must be notified an once. To Be Completed by Funeral Director	19e. Informent's Name/Ralations	-		19b. Mailie	ng Address (Street					Stata, Zij	Coda)		
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re,	THE PERSON	20a. Mathod of Disposition 20b. Placa of Disposition (Nama of Data 20c. Location - City or Town,												
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Baltimore,	orten Inju	21. Signeture of Funeral Service	1 0 1	0 1 1 0 7										
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		shock, or heart failure. List	only one ceuse on	eech line.	in. Do not am	iai ine moda or dyi	ing, such as	Cardiac or res	photory arras	ι,	- 1	Intarval Batween Onset end Deeth		
	Physician /Medical	Immediata Ceusa (Final												
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P	de la late	Due to (or es a consequence of):												
	min min	Commence of the	b. Atr	ial Fib							1	Years		
_6	et the death certificate be executed d by the attending physician and letached for use as the burlat-transit Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate												
68760,	sicial burn	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Dua to (or as a consequence of):												
89	ficate pphy is the	that initiated events rasulting in death) Last Dua to (or as a consequence of): d.												
XO	nding use e													
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18	death death the	3 Suicide 6 Could		o of Injury . At h	nome form of	raat, factory, office			ocation /Stre	et and Numb	er or Ru	ral Route Number,		
Division of Vital Records,	tal or Attending P sa ther death. si Director: After t led in by the funers Certification:	4 ☐ Homicide determ		ding, atc. (Speci		raat, factory, office			City or Town,		0, 0, 110,	ar 1100,0 110		
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	To the Hospital or Attending Physician: The lew within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		ng Physician: To the Examiner: On the I	basis of axamin										
	within 2 the comple	29b. Signature and titla of certifie		nnar stated.		29c Licen	se number		29	t Data signed	1 (Month	Dev Year)		
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	75	OF PEL	nue	cer	<u> </u>	0 9	021	0.	I ^M	ay Z,	2000			
		30. Nama and addrass of person					G!	01	36.1	20015				
		Dennis Cullin,				e. #1625	Chevy	Chase	, Md.	20815				
	State	Anna Maria M												
	Registrar	MAY 05			N.	KARA COLANA	April 1							



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Yaai **Physician** April 30, 2000 10:41 am Margaret S. Hays /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1□M 2X F 77 Yrs. Director April 7,1923 236-22-2557 West Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other trsumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2-E 20906 death Funeral 3408 Chiswick Court, USA 12. Was Decedant Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Rem 27 is marked other than "natural", or item and effect the many injury or other treumatic event, the treumatic should be the treumatic event, the treumatic should be the treumatic event, the treumatic should be the treumatic event, the treumatic should be the treumatic event, the treumatic event, the treumatic event the treumatic event. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Maryland 21215-0020 Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Printing Industry Secretary 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be 2 Kathleen Farkas Steve Sabo 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Briars Knoll Way, Hanover, MD 21076 Stephanie D. Manko/ Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 5/3/00 Silver Spring, MD 22. Nama and Addrass of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W, Silver Spring, MD20901 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Ceuse (Final disaase or condition resulting in deeth) /Medical 15 NOURS cerebral hemorrhage Examiner Due to (or as a consequence of): Examiner certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last burial-tran Dua to (or as a consaquance of): and Records, P.O. Box 68760 Physician/Medical the Due to (or as a consequenca of) usa es 0 23b. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be datached 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of causa of deeth? 24a. Wes an eutopsy Completed performed' page 2 1 Yas 20 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director 25. Was case refarred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2. To the 6 29d. Data signad (Month, Day, Year) 29b. Signatura and title of certifier 29c. Licensa number APRIL 30, 2000 024543 a . Room m.D 10

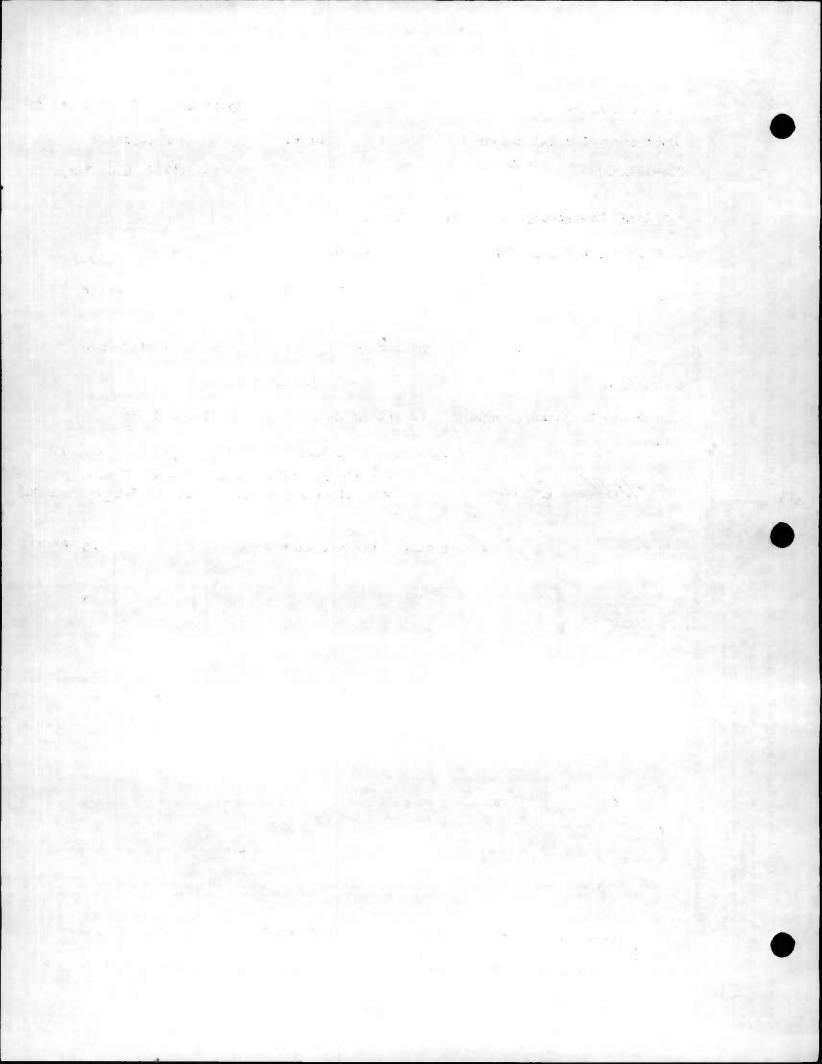
State Registrar

31. Date filed (Month, Day, Year)

MAY 0 2 2000

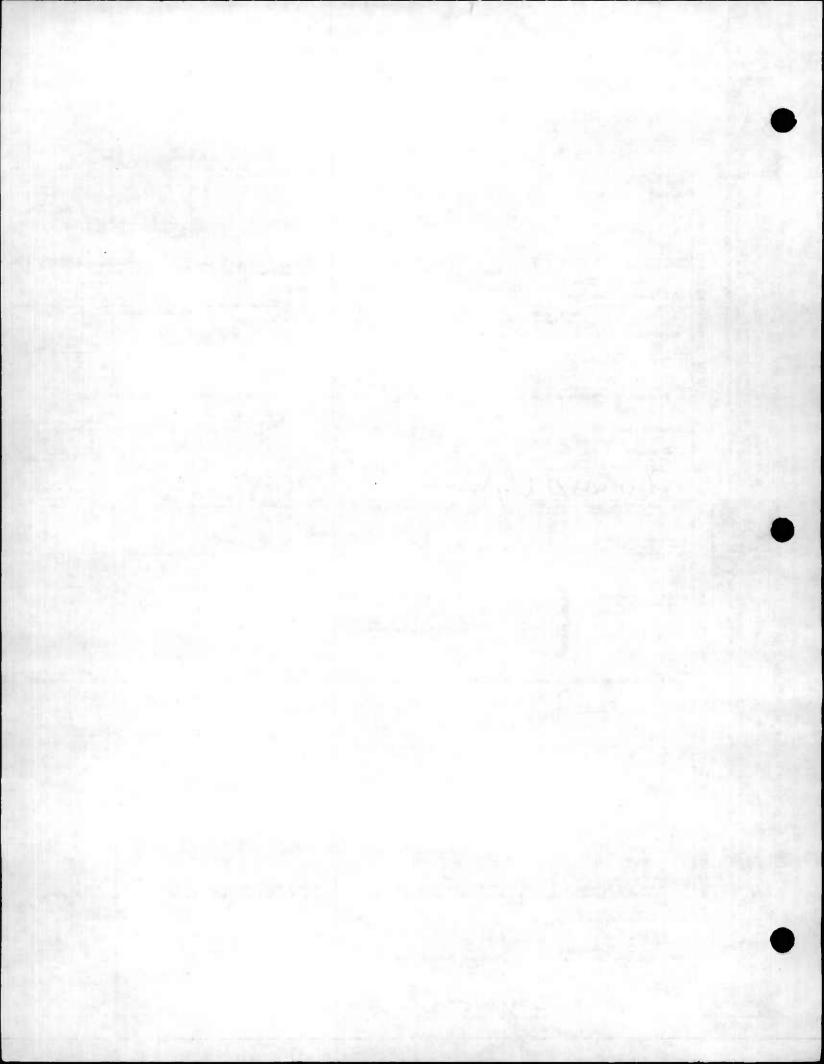
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TAMES A. ROSSI, M.D. 3305 N. Lellare WORLD BLVD., SILVER SPRING 32. Registrar's Signature books



Please Type or Print In Black Indeiibie Ink. Assure All Copies Are Legibie, State of Maryland / Department of Health and Mental Hygiene

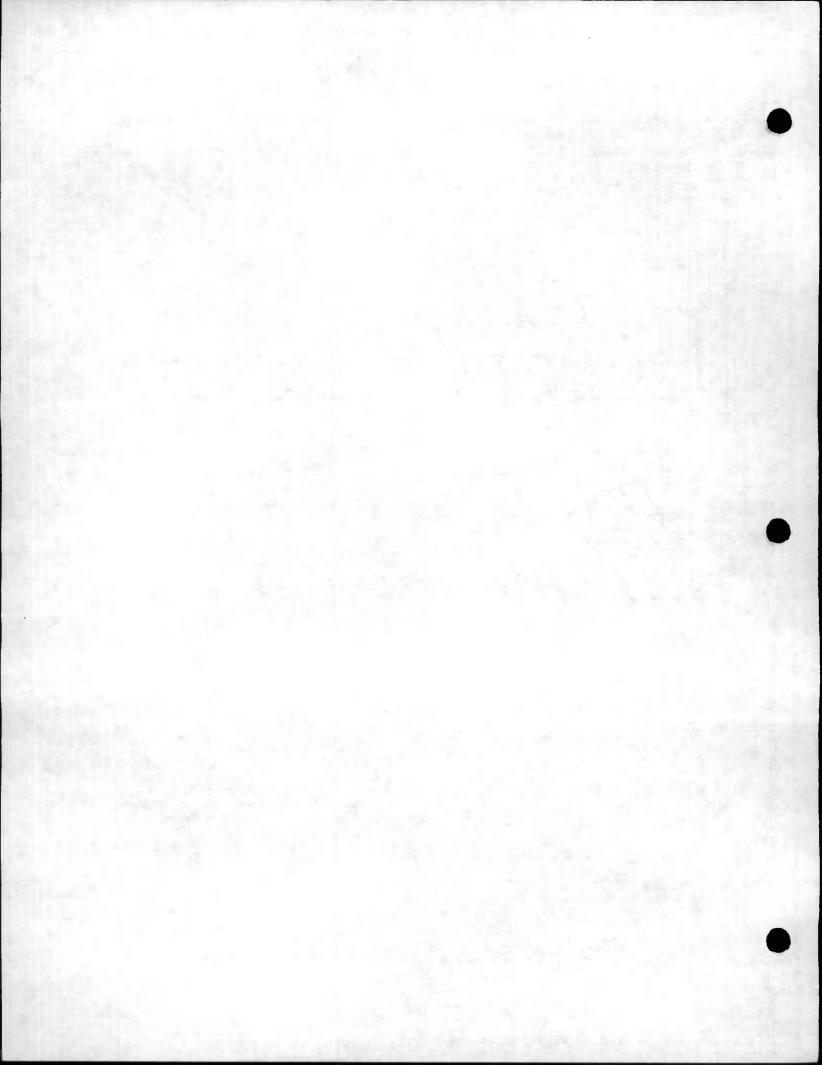
	_	1. Decedent's Name (First, Middle, Last)				tificate of		2. Data of De		3. Time of Deat	
Physiciai /Medica		Barbara Hazel						April	26, 2000	12:45 P	
Examine		4a Facility Nama (If not institution, give :	treet and number)			4b. City, Town, or I	ocation of Deeth	4c. County of	Death	
		8503 Wilkesboro I	ane				Potomac		Montgo		
Funeral Director		317 40 0031	M 2□KF 7. A	ge (In yrs. last 70	t birthday) Yrs.	Months Days		8. Data of Bir (Month, De Oct • 2]	th y, Year) 1, 1929 W	Birthplace (Stata or For Country) ashington,	
	-	Usual Residence of Decedent 10a. State 10b. County	y 10c. City, Town or Location							10d. Insida City Lin	
t or 28s-f show be notified at	otor	Maryland Montgome	ry	Poto						M∏Yas 2□	
		10e. Street and Number 8503 Wilkesboro La	ine			10f. Zip Code 20854			10g. Citizen of What United S		
Exam.	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	t Ever in U,S. ? No		/as Decedent of Yes, specify Cul ☐ Yes 2 X No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yas or No o Rican, atc.)	Spacific	Amarican Indian, Whita, etc. African American	
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122		Benjamin Hazel	Husband	i	8503	Wilkesb	oro Lane,	Potomad	e, MD 20	854	
nent of He net: If Item rry or othe	-	20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State			osition (Nama of material Park Data 20c. Location - City or Town, Stata Memorial Park 5/2/00 Landover, Maryland					
Departm Importa any inju onsa.		21. Signature of Funeral Service License	Chil	un	Mc Mc	Name and Addr	ess of Facility Uneral Se	rvice.	Inc.	ton, D.C. 2	
200	Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b								
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page	3							10	Yes 2 No	1 ☐ Yes 2 ☐ No	
octor d	9	25. Was casa refarred to medical axaminer?					26. Place of Dea	ith (Check only o	ona)		
2 P	0	1 Yes 2 No 27. Manner of Death Platural 5 Pending investigation	28a. Date of Inj (Month, Da		/Outpatient b. Time of tnjury	28c. Inju			dance 6 Other		
within 24 hours effer death. To the Funeral Director: Affectoring in the fune completely filled in by the fune the fune fune fune fune fune fune fune fun	Certification	3 Suicide 6 Could not be detarmined	28e. Place of In building, e		28f. Location (: City or Tou		or Rural Routa Number,				
in 24 hound he Funera pletely fille		29a. Certifier (Check only one) 1 Certifying Physics Check only 2 Medical Examin		of axaminetion							
12	Σ :		mel			В 930	se number 082		29d Data signed (
		 Nama and address of person who co Bruce R. Kressel, 					nue, Suit	e 214, (Chevy Cha	se, MD 2081.	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** May 03,2000 3:40 P.M. Philip C. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, giva street end number) 4c. County of Death Examiner Prince George's 10001 Mike Road Ft. Washington If Under 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) May 15,1927 Birthplaca (Stete or Foreign Country) 7. Age (In yrs. last birthday) Funeral Deys Hours Months 152 M 2□ F Yrs Korea 72 Director 578-86-2197 Usual Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits flem 27 is marked other than "natural", or flems 23s or 25s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 25 No Director MD Prince George's Ft. Washington 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number United States of America 10001 Mike 20744 permit. Pages 1 and 2 should be filed within 72 hours effer death v Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s and injury or other traumatic event, the Medical Examinet mantal once. Road Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Stetus 1 Yes 2 No If Yes, Give Yaar or Detas: 1 ☐ Never Merried 2 ☑ Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince George's Elementery/Secondery (0-12) College (1-4or 5+) Liquor Inspector County Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 Kim Chill Mann Ho Chae Yeo1 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) 10001 Mike Road Ft. Washington, Maryland 20744 Wi Han Ho/ Spouse 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 5/5/00 Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signeture of Funerel Service Licens 11800 New Hampshire Ave. Silver Spring, MD 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, only one cause of each line. 26a. Pert1. Enter the dis Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel 16 months diseese or condition resulting in deeth) Homach Examiner Due to (or es e consequence of): Examiner Mates physician and the burial-transit that the death certificate be executed Sequentielly list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): attending P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? the th á 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, p 24b. Were eutopsy findings aveileble prior to 24a. Wes an eutopsy Completed cancer completion of causa of deeth? The law page 2 1 Yes 2 No 1 Yas 2 No certificate 25. Wes cese referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 this To the Hospital or Attending Phywithin 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? edical Certification: 1 Netural 5 Pending 1 ☐ Yas 2 ☐ No investigetion 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. (Check only one) 29c. Licensa number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier 14905 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 20740-3231 Year-Kwon H. Yoon, M.D. 7307 Baltimore Ave. #111 College Park, MD 31. Dete filed (Month, Dey, Year) 32. Begistrer's Signature State MAY 05 2000 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State

of Maryland / Department of Health and Mental Hygiene	1)				7
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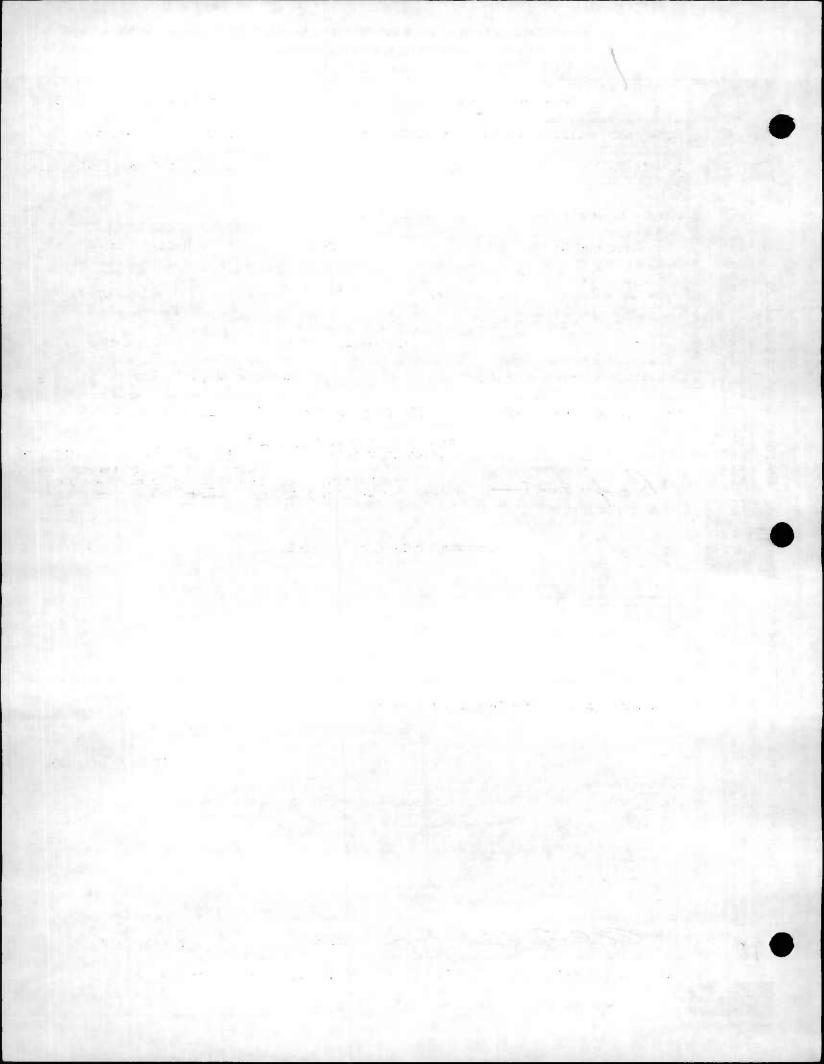
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State of Maryland / Department of Health and Mental Hygiene

					Ce	Tificate (of Death		Reg. No.				
cian lical	al Ruben nottinger may 1, 2000										3. Time of Death 4:45 PM		
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21	4-12-75	33	1X M 2□ F	87	rs. lest birthday) Yrs.		ays Hours	Min. (Monti	of Birth h, Dey, Year) 2, 1912	West	Virginia		
	State	10b. County		10c.	City, Town or Lo	cation			10	d. Inside City Limits			
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17. F	the second second	First, Middle, Las		nger				iddle, Maiden Suma ginia Br					
19a.	Informant's Na	me/Relationship	(Type, Print)			-		umber, City or Tow					
Se	1ma B.	Hottinge	er/Wife		516 I	ongwood	d Drive,	le, Mary	land 20)850			
		Cremetion 3		State F	D. Placa of Dispo cemetery, cre lower Hi	sition (Neme of natory or other Chu	rplace) rch of t	he May 4,	20c. Location	n - City or Tow			
-		5 ☐ Other (Spec			Brether	Cemet	ery	2000	Gaithe	, Maryland			
	Ro	14	~_	мо	Ro	ckvill	e, Inc. e, Maryl	300 Wes	t Montgo 550-2805	mery A	eral Home, venue		
23a.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.												
diser	ediate Cause (I ase or condition liting in death)		a. Inte	Due to	a1 Pu1mo	quence of):	ibrosis				5 Years		
Caus Caus thet resu	uentielly list cor y, leading to im ie. Enter Unde se (Disease or I initieted events Iting in death) L	rlying njury ast	c	Due to	o (or as a consec	uence of):							
Part	II. Other signific	cant conditions	contributing to d	death but not	resulting in the u	nderlying caus	e given in Part f.	23b.			the ceuse of death		
	Chronic	Obstru	ctive Pu	1mona	ry Disea	ise			XXYes 2□ No	3 ☐ Prob	ably 4 ☐ Unknow		
								24a.	Was an autopsy performed?	com	re autopsy findings ilable prior to appletion of cause eath?		
									1□ Yes ZZNo	10	Yes 2 No		
	Mar ages refers	ad to modical					00 Plans		100000				
23. 9	Was case refern		Hospital:				Othor	of Death (Check					
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27. N	Manner of Death Naturel Accident	5 Pending investigation	on	of Injury oth, Day Year	28b. Time o Injury		Injury at Work? 1 ☐ Yes 2 ☐ N		ribe how injury occ	urred			
3	3 ☐ Suicide I ☐ Homicide	6 Could not determine	A 200. Flag	a of Injury - A ling, etc. (Spe	it home, farm, st ecify)	eet, factory, of	fica		ion (Street and Nu or Town, State)	mber or Rural	Route Number,		
27. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Placa of Injury - At home, farm, street, factory, offica 28f. Location (Street and Number or Rural City or Town, Stete) 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred North occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Nort											ated. the causa(s)		
29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month										ned (Month, E	Jey, Year)		
30 N	lame and addre	ess of person who	completed cau		Item 23e) (Type		33443		May 3	, 2000			
A	30. Name end address of person who completed cause of death (Nem 23e) (Type, Print) Alan R. Pollack, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851												
ate ^{31. C} trar	Date filed (Monti	AY 05		Registrar's SI		Space	(h)						
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3. Time of Deeth

30 minuets

Physician		_									Month	Dey	Year	5 10PM	
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i Director		e. Street and Nu	mber Green Dr	rive			10f. Zip	Code 2101	2		1	0g. Citizan of USA	What Cou	ntry?	
miner must	11	. Maritel Stetus	ied 2 Married	12. Was Dece Armed Fo 1 X Yas	rces? 2 ☐ No T	U,S. 13.	If Yes, spe	cify Cubi	an, Mexican,	in? (Specify Puerto Rica	Yas or No- n, etc.)		ck, White,		
۵		3 XWidowed	4 ☐ Divorced	If Yas, Giv Year or Do	e v	AMTT	1 🗆 Yes	2 XNo	Specify:			White			
9		(Spec	15. Decedent's Ed	ucation de completed)		16a. Dece	dent's Usua	al Occup	ation	of working		16b. Kind of Business/Industry			
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To Be C	17	James H	(First, Middle, Last) ayes							's Neme (Fir e Osbo	irst, Middle, Maiden Sumeme) DEN				
-	15	e. Informent's Na Jeff Hay	ame/Reletionship (1	Type, Print)		19b. Meiling Address (Street end Number or Rure 5778 Londonderry LP NW						o Code) 8312			
	20	a. Method of Disp	position Cremation 3 5 Other (Specifi	Removal from t	100	cematery crametory or other pleca) Mass 1							Location - City or Town, State		
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hed for use as	d. Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa givan in Pert I. 23b. Did									23b. Dld to	obacco use co	ontribute t	o the cause of death?		
or Attending Physician: The law requires that the after deeth. Director: After this certificate hes been signed by the funeral director, page 2 should be deteched in by the funeral director, page 2 should be detechentification: To Be Completed by Physertification:											1 🗆 Y	ea 2 No	3 Pro	obably 4⊠Unknown	
						Í'n,					24a. Wes e parton	n autopsy mad?	8/	Vere eutopsy findings vailable prior to omplation of causa I deeth?	
Page											1₽ ٧	as 2 No	1	□Yas 2□No	
Physician: The rthis certificate haral director, page		. Wes casa rater examiner?	red to medical						26. Pleca	of Deeth (Cl	hack only or	10)		A	
5 0	L	1 Yes 2		-		☐ ER/Outpatie			4 LI NUI	rsing Home	5 🗆 Reside	ence 6 Ott	har (Speci	ify)	
After fune		. Menner of Deat 1 DNaturel 2 Accident	5 Pending investigation		of Injury h, Dey Year)	28b. Time (of M	28c. Injui Woi 1 □	yet k? Yes 2 □ N		Describe ho	ow injury occu	rred		
To the Funeral Director: After to completely filled in by the funeral Medical Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	288. PIECO	28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						Location (Si City or Town	treet end Num n, Stete)	ber or Rur	al Routa Number,	
pletely fille edical (25	a. Certifier (Check only one)	1⊠ Certifying Ph 2☐ Medicat Exam	iner: On the ba	best of my kr asis of examin her steted.	nowledga, daa netion and/or in	h occurred evestigation	at tha tir	me, date end pinlon, daet	d pteca, end o h occurred a	due to the c t tha time, d	euse(s) end m late and placa,	enner as a	stated. to the causa(s)	
Me		b. Signature and	title of certifier			71.17	29		e number		2	9d. Data sign	ed (Month,	Day, Year)	
•		THE WAY					128260				4/28/00				

30. Name and address of person who completed causa of deeth (Item 23e) (Type, Print)

32. Begistrar's Signeture

31. Dete filed (Month, Day, Year)

MAY 0 2 2000

1 Decerlent's Name (First Middle I set)

State

Registrar

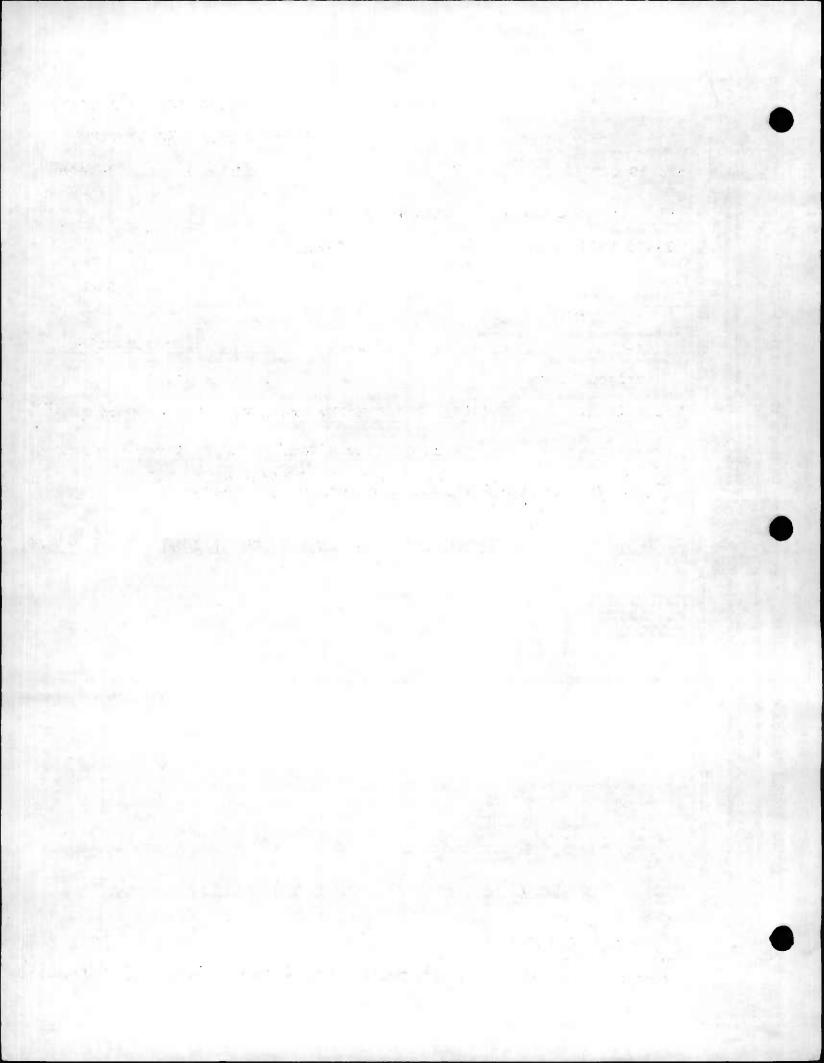
Daniel R. Meldrum MD 600 N Wolfe Street Baltimore, MD 21287

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death Month 3. Time of Death Dey Vest **Physician** CHESTER HAMMOND 26, April 2000 4:08 Pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 15400 Holly Grove Rd, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. May 12 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** , 1925 1⊠M 2□ F Yrs Director 578-38-3691 Usual Residence of Decedent Maryland deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** netural, or hams 23s or 28s-f shortified Examiner must be notified at 1 ☐ Yes 2X No Director Montgomery MD Silver Spring 10e. Street and Number 10g. Citizen of What Country? 15400 Holly Grove Road 20905 U.S.A. Funeral 14. Rece · American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours efter 1 Never Married 27 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 lack 1 Yes 2 No Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hyglene. Elementary/Secondary (0-12) 7 th College (1-4or 5+) Self-employed Construction permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: if fem 27 is marked othe eny Injury or other treumatic avent, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harrison Hammond Roberta Williams 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 9 0 5 19a. Informant's Name/Relationship (Type, Print) Patricia A. Hammond 15400 Holly Grove Rd., Silver Spring, (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem. 5/1/00 Silver Spring, 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 21. Significant of Funeral Service Licens EOV ROCKVILLE, MD 20850 23a. Part1. Enter the dis tions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy The law page 2 1 Yes 2 No No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physicien: 25. Was case referred to medicat examiner? e 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Affe completely filled in by the fun. 5 Pending 1 TYes 2 □ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 8 of death (Item 23a) (Type, Print) TOR DRIVE ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature State 01 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARTIN JANNEY APRIL 30,2000 3:50 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) Months to M 2 F Yrs. 83 AUGUST 6,1916 125=10 9559 NEW YORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1X Yes 2 No Funeral Directo FLORIDA BROWARD COCONUT CREEK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4025 CARAMBOLA CIRCLE NORTH 33066 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No WW I I If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2√€ No Specify WHITE Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 FRANK JANKOWITZ ANNIE GOODMAN ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY JANNEY WIFE 4025 CARAMBOLA CIRCLE NORTH COCONUT CREEK FLA. 33066 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition MAY 2 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) COMFORT CREMATORY 2000 ALEXANDRIA VA. 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 21. Signature of Funeral Servica Licensee 20852 1170 ROCKVILLE PK. ROCKVILLE MD. 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY DISTRESS SYNDROME 1 WEEK Due to (or es a consequenca of): MESENTERIC ISCHEMIA Examiner 2WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): INFARCTION OF THE SMALL BOWEL 2 WEEKS Physician/Medical Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? à Completed Be Certification: To

The law requires that the death certificete be executed buriel-transit ending physician r use as the buriel Box 68760, signed by the ar P.O. I Records. pege 2 should Division of Vital Hospital or Attanding Physician: '24 hours after death.'
Funeral Director: After this certifica To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. Important: If item 27 is merked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar ment be notified.

Baltimore, Maryland 21215-0020

CARCINOMA OF BLA	DDER	1 □ Yee 2 2	No	3 Probably	4 ☐ Unknown					
ALZHEIMERS DEMEN	TIA		24a. Was an autops performed?	24a. Was an autopsy performed? 24b. Were autop evailable pri completion of death?						
					1 ☐ Yes 2 🔀	No	1 ☐ Yes	20XNo		
5. Was case referred to medical		100		ath (Check only one)	th (Check only one)					
examiner?	Hospital: 1 Anpatient 2	ER/Outpatient 3□	DOA	Home 5 Residence 6 Other (Specify)						
7. Manner of Death 1. Natural 5 Pending 2 Accident Investigation		28b. Time of Injury M		Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occu	rred			
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)								

🖎 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Dete signed (Month, Day, Year)

APRIL 30,2000

29c. License number

D51908

State Registrar

Medical

29a. Certifier (Check only one)

DAVID MAGLIARO M.D.

MAY 03 2000

31. Date filed (Month, Day, Year)

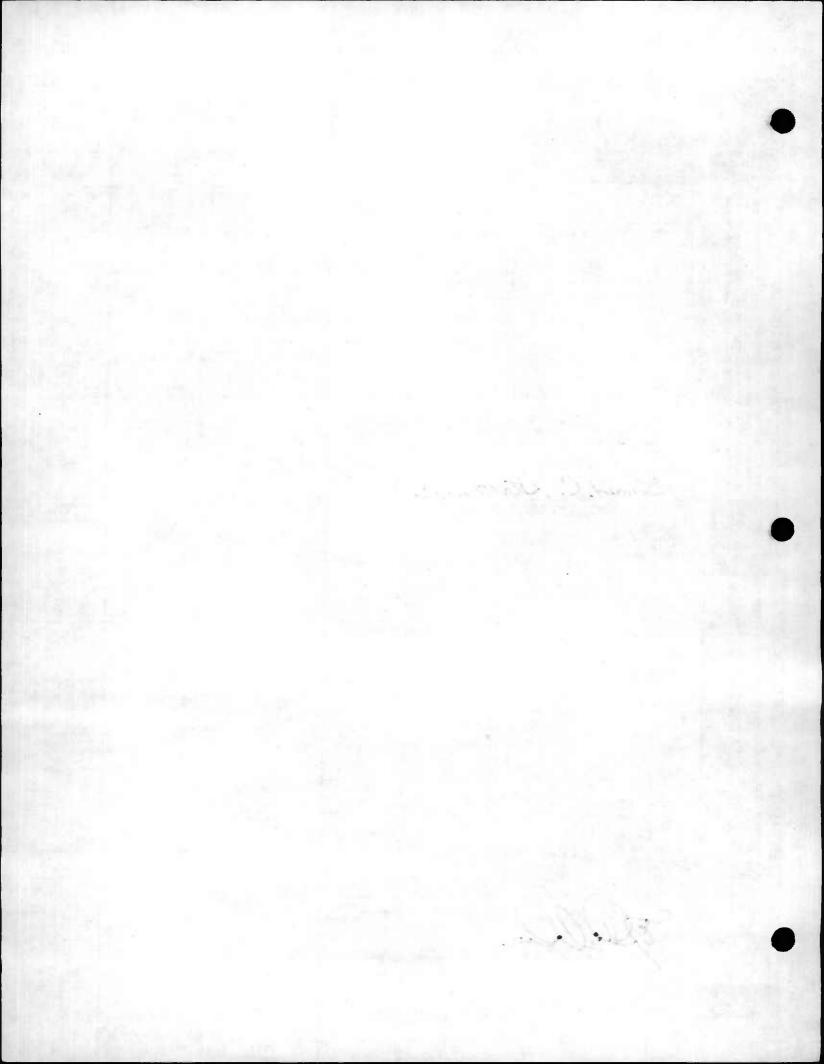
32. Registrar's Signeture

manner stated.

nd address of person who completed cause of death (Item 23a) (Type, Print)

PRINCE PHILLIP DR.#327 OLNEY, MD. 20832 18111

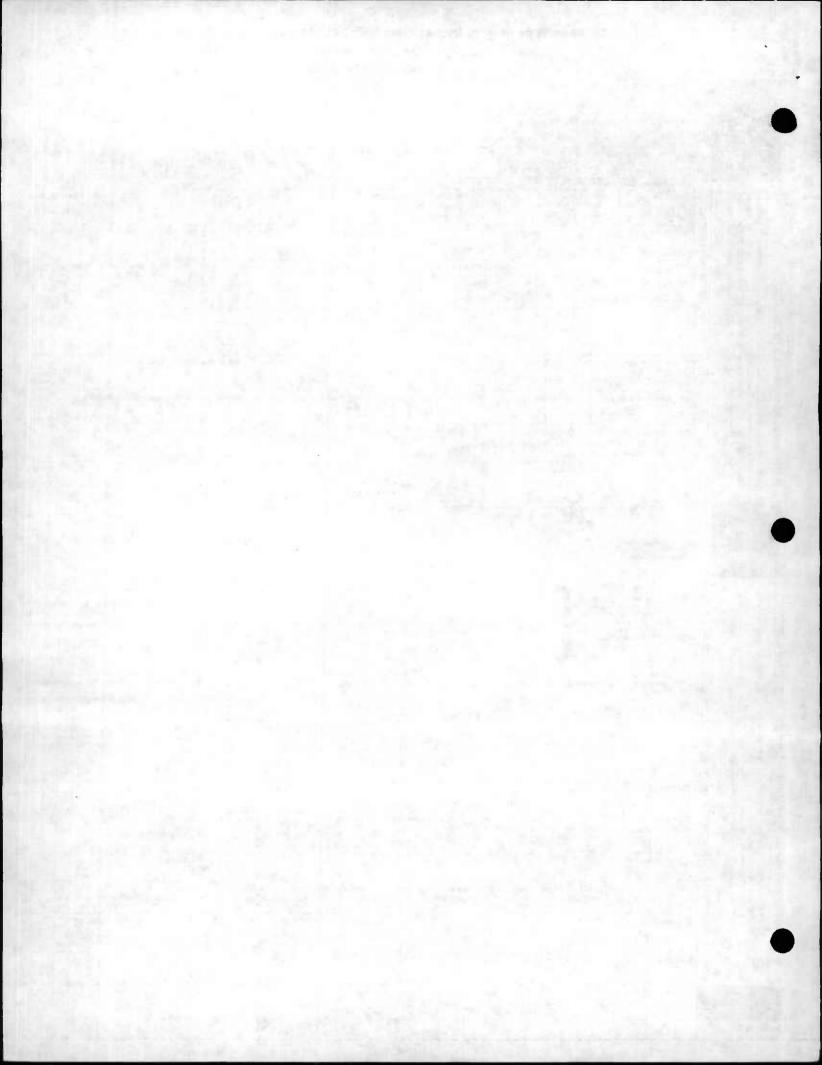
DHMH 16 Rev 6/95



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	State	of Maryland / Department of Health and Mental Hygiene	58	13
20	RMW Monta Co	Certificate of Death		

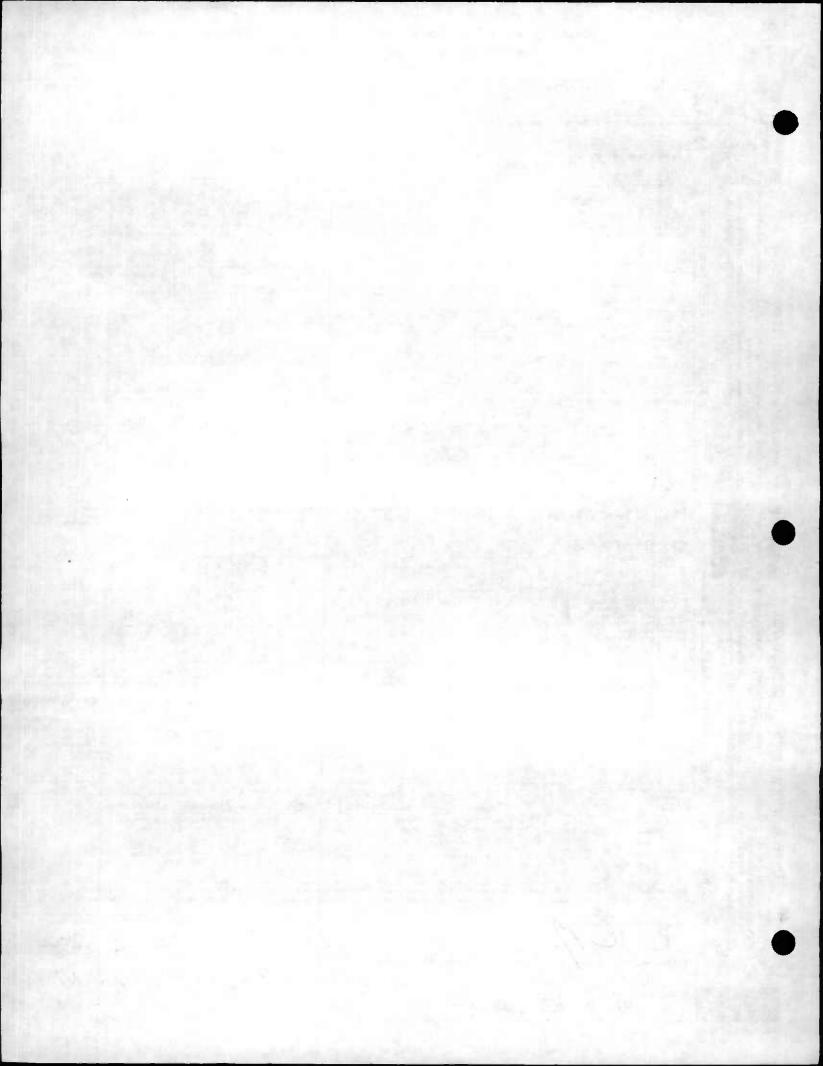
Am	end #19b	5,5	/11/2000, BMW, Montg. Co. Certificate of Death Reg. No.										
	Dhuninian	_	Decedent's Nama (First, Middle, Last)						2. Data of De Month	ath Day	Yaar	3. Tima of Death	
dig	Physician /Medical	_	Dhanessar Jl	nappan					April 2			3:35 AM	
	Examiner	_	4a Facility Nama (If not institution, give street and number) 4b. City, Town						Location of Death	4c. County	of Death		
			6329 Lenox Road					Bethes		Mo	ontgo	mery	
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. B								9. Birthp	olace (State or Foreign	
	Director	-	216-47-3357 1 M 2 F 83 Yrs. Months Days Hours Min. (Month, Day, Year) Country) Guyana										
1215-0020	atter death with the Maryland or frems 23s or 28s-f show infract must be notified at Funeral Director	-	Usual Residence of Decedent										
		10e. State 10b. County 10c. City, Town or Location									10d. Inside City Limits 1 ☐ Yes 2 No		
	vith the Ma or 28s-f a be notified	2	Maryland Montgomery Potomac										
	Vith Vith		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									ntry?	
	fler death v	8	8805 Quiet Stream Court 2085							Guyana			
	ab re		11. Marifaf Stafus	12. Was Decedent I Armed Forcas?		 Wes Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 			specify Yes or No to Rican, etc.)	Ble	14. Raca - American Indian, Bleck, White, etc.		
20	urs after		1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:		1 ☐ Yas 2 No Specify:				Specify	Specify: Forth Tolds		
e, Maryland 2	natural',					10 0 1				10) 10: 1 10		st Indian	
	ed within 72 ho yglene. ver than "neturi rt, the Wedical I	200	15. Decedent's E (Specify only highest gri		le completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of B	usiness/in	dustry	
	within and then then		Elementary/Secondary (0-12)	Collega (1-4or 5+) 5+									
	BEE TO		17. Father's Name (First, Middle, Last			_	Attorne	-	me (First, Middle,		Jaw ne)		
	Se Se Se								Sukni				
	2 should be and Menta is marked aurmatic every	-	19a. Informent's Neme/Relationship (Ramjhappan						al Route Number, City or Town, Stete, Zip Code)			
	- E - E		Rajesarie Jhappar				Uniet						
	of Heelth Hem 27 offher tr	-	20a. Method of Disposition	1/WITE			ition (Name of	ream Cou	Date Date	mac, Ma			
	Pages nent of int: If the iny or o	ľ	1 ☐ Burial 2 ☐ Cremation 3 ☐		cen	cemetery, crematory or			May 3,				
	permit. Pages Department of Important: If it any Injury or of		4 Donation 5 Other (Special		Monte					Bethesda, Maryland Pumphrey Funeral Home/			
39	Amportant Indiana		21. Signature of Funeral Service Lice		01126	22. Ro	theed and	rass of Facility KO	pert A.	Pumphre	y Fur	neral Home/ onsin Avenue	
	00 = e a		VIT 60	7	31120	Be	thesda,	Maryland	20814-3	501	WISCC	nis in Avenue	
F			23a. Part1. Enter the disease, or conshock, or heert failure. List only	plicetions that caused	the death.	Do not ente	r the mode of dy	ring, such as cardia	c or respiratory a	rrest,		Approximate triterval Betwaen	
	Physician											Onset end Death	
ĸ(/Medical		Immediate Cause (Final disaasa or condition Progressive Respiratory Failure									4 Weeks	
	Examiner	-	resulting in deeth)	esulting in deeth) Due to (or es a consequenca of):							4 110		
	T	<u> </u>	Severe Parkinson's Disease										
	ing physicien and es the burial-transit		Sequentially list conditions,				5 Years						
o o	en a urial-		Sequentially list conditions, if any, leading to immediate cause. Enter Undertying								i		
of Vital Records, P.O. Box 68760, Propied in the least cartificate be executed.	ficate be physicie as the bur	2	Ceuse (Disease or injury thet initiated events rasulting in death) Last										
	ng ph ng ph ng ph		resulting in death) Last Dua fo (or as e consequenca of):								1		
	that the death ceed by the attendidetached for use	2	Part II. Other significant conditions of	23b. Did	lobacco uae co	ontribute t	to the cause of death?						
	_ 0 = -		art II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part f.							1 ☐ Yee 2 ☐ No 3 ☐ Probably 41 ☐ Ui			
	5 90 >	2	Pneumonia							, R			
	quire on sig	3							24a. Was	24a. Was an autopsy performed?		24b. Ware autopsy findings available prior to	
	w requir	2							perio	rmear	CC	ompletion of cause	
	0 - 5 -								10	Yes 210 No		☐ Yes 2☐ No	
	certificate rector, pag		25. Wes case referred to medicat					OS Blace of Do				0 163 20 160	
5	Physician: this certific ral director,		examiner?	Hospitat:		D/O +	00000		ath (Check only		(6	Daughter's	
o	Physic rthis o		27. Menner of Death	1 ☐ Inpatie		R/Outpatient 8b. Time of	3LI DOA	4 Unursing	*	how injury occur		vResidence s	
0	tal or Attending P rs after death. el Director: After t led in by the funers Certification:	5	1 Neturat 5 Pending investigatio	g (Month, Dey Year) Injury Work?									
S	deat deat ctor: y the	2	3 Suicide 6 Coufd not b	90 COn Place of Leiters At home from asset for the office of the				28f. Location (28f. Location (Street and Number or Rural Route Number,				
ā	or Attendent after deat Director:		4 ☐ Homicide determined	building, etc. (Specify)					City or To	r Town, Stete)			
	Hospital 24 hours Funeral ataly filled		One Continue ATT Continue District To the Cont										
	n 24 hours no 24 hours no Fune pletely fi	2	29e. Certifier (Check only one) (Check one) (Check one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification		29b. Signature and title of certifier 29c. License number								29d. Dafe signed (Month, Day, Year)		
	_		Soor Jalele O. D. D50637							April 29, 2000			
	10	-											
		1	30. Name and address of person who completed causa of death (Hem 23a) (Type, Prinf) Shakun M. Malik, M.D. 106 Irving Street, N.W., Suite 420, Washington, D.C. 20010										
			Shakun M. Malik, 31. Date filed (Month, Day, Year)		Irvi	ng St	reet, N.	.W., Suit	e 420, W	ashingt	on, J	D.C. 20010	
	State Registrar			32. Registra			Spork	,					
	Registrar		MAY 02 20	JUU LIZAR		LI.	spark	2					



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State of Maryland / Department of Health and Mental Hygiene

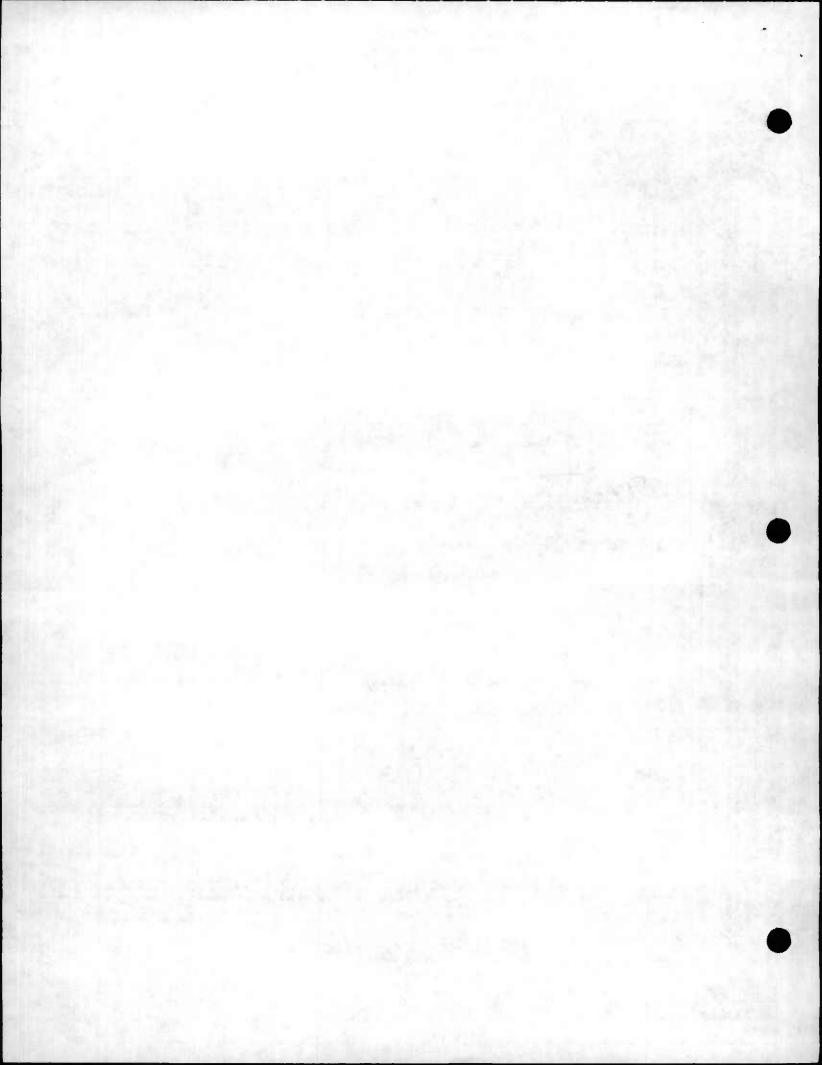
			C	ertificate of	Death	R	eg. No.	100/2
	1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dear	th	3. Time of Death
Physician Medical/	Elizabeth Mary J					April 3	0, 2000	8:30 pm
Examiner	4a Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or L	ocation of Death	4c. County of	Death
	Manor Care Silve 5. Social Security Number 6.		foot bidbala	If Under 1 Yeer	Silver SI	ring	Montgo	
Funeral Director		Sex 7. Age (In yrs		Months Days		8. Date of Birth (Month, Day Sep 12	, 1904 E	9. Birthplece (State or Foreign Country) ngland
9 .	Usual Residence of Decedent	140.0						Lead to the annual to
aryta ahoe det	10a. State 10b. County	10c. C	ity, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
or 28s-f	Maryland Prince	George's Ade	lphi	Total Till Co.				
with the Marylar Sa or 28e-f show it be notified at	10e. Street and Number 2304 Seminole St:	root		10f. Zip Code			Og. Citizen of Wh	at Country?
her death v r hems 23s siner must. Funeral	11. Maritel Status	12. Wes Decedent Ever in I	J,S. 13	20783 B. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp			American Indian,
9 09 -		Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give Yeer or Detes:		If Yes, specify Cub 1 ☐ Yes 2 No		Rican, etc.)	Specify:	White, etc. White
flied within 72 hours Hygiene. fiber than "natural", ant, the Medical Exa ant, the Medical Exa	15. Decedent's E (Specify only highest gr	ducation rade completed)	(Gi	cedent's Usual Occup ve kind of work done	during most of work	king	16b. Kind of Busi	ness/Industry
han han	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retire	d)			
Per Per Co	17. Father's Name (First, Middle, Las	r)	Laur	ndry	18 Mother's Nam		Laundroma Maiden Sumame)	_
2 4 E C	Desired to the second	,				io įr not, madio,	naidon damaine,	
공조들법 는	Unknown 19a. Informant's Name/Relationship	(Type Print)	19h Ma	iling Address (Street	Unknown	ra i Route Numbe	r City or Town S	tate Zin Code)
似年豐富	Rosemary Herlihy							
of Health Hem 27 other tr	20a. Method of Disposition		Piace of Dis	Seminole position (Name of	1,172-1,191-1	Date	20c. Location - Ci	
Special of the specia	1 Burial 2 Cremation 3	Removel from State		rematory or other planard and S		May 5	New Have	en, CT
Party S	21. Signature of Funeral Service Lice			22. Name end Addre	ess of Facility			
88EE8	Palanua & F	Jan Dan		Francis J			-	inc. pring, MD 20901
	23a. Part1 Enter the disease, or con shock or heart failure. List only	nplications that caused the dea	ith. Do not e	enter the mode of dyi	ng, such as cardiac	or respiratory ar	est,	Approximate Interval Between
Physician	Shock of heart tailore. List only	one cause on each line.						Onset and Death
/Medical	Immediate Cause (Final disease or condition	a Coronary Ar	tery T)isease				1 year
Examiner	resulting in death)			sequence of):				1 year
icate be arecuted physicien and s the burial-transit	Sequentially list conditions,	Due to	or as e cons	equence of):				
cien (cien do nuital	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c .						
licate be physicie the bur	that initiated events resulting in death) Last	Due to (or as a cons	equence of):				
ding ph		d						1
es that the deeth ce igned by the attendi be detached for use by Physician/I	Dark Other classes				Carlo Book	not Dida		ribute to the cause of death?
res that the de signed by the a loe detached to by Physic	Pert II. Other significant conditions	contributing to death out not re	sulling in the	underlying cause gr	ven arranti.			Probably 4 Unknown
The law requires that the deeth certificate be assected to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Exami	Anemia							
been sig should b						24a. Was a		24b. Were autopsy findings evailable prior to
The law requires the law requires the law requires the law requirements that the law requirements the law requirem						parior		completion of cause of death?
the law						1 D Y	es 2 XNo	1 ☐ Yes ŽÜ No
					26. Place of Dea	ith (Check only or		
Physician: rthis certifica and director, p. To Be C	examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpat	ient 3 DOA Ot	hor		ence 8 ⊡Other	(Specify)
g Ph		28a. Date of Injury (Month, Day Year)	28b. Time		iry at	28d. Describe h	ow injury occurred	d .
Attending Physician: r death. ector: After this certific by the funeral director, lification: To Be (1 Natural 5 ☐ Pending 2 ☐ Accident investigation	on	,		Yes 2□No			
	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of Injury - At building, etc. (Spec		street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
ral Dir led in								
To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier X Certifying P (Check only one) 2 Medical Exa	hyelcian: To the best of my kn miner: On the basis of examin	owledge, de ation and/or	ath occurred at the ti Investigation, in my	ime, date and place opinion, death occu	, and due to the or rred at the time, o	ause(s) and mani late and piace, an	ner as stated. Id due to the cause(s)
To the Hospital of within 24 hours at To the Funeral Discompletely filled i Medical Ce		and manner steted.		29c, Licen	se number		29d. Date signed	(Month, Day, Year)
1	b ////	andia		0	2543/)	11	0 0
Q	30. Name and address of person who	completed cause of death (the	m 22a) /T	e Print	. , , , ,		1194	2,2000
	Jaw M	4RGOLIS /	395	L Relli	more A	K. L	wel M	0 2027
State	31. Date filed (Month, Day, Year)	32. Pegistrer's Sign	neture /	1			1	
Registrar	MAY 03 2	300 Senera	Ø.	sporks				



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State of Maryland /	Dep	artme	nt of	Health	and Me	ental Hygiene
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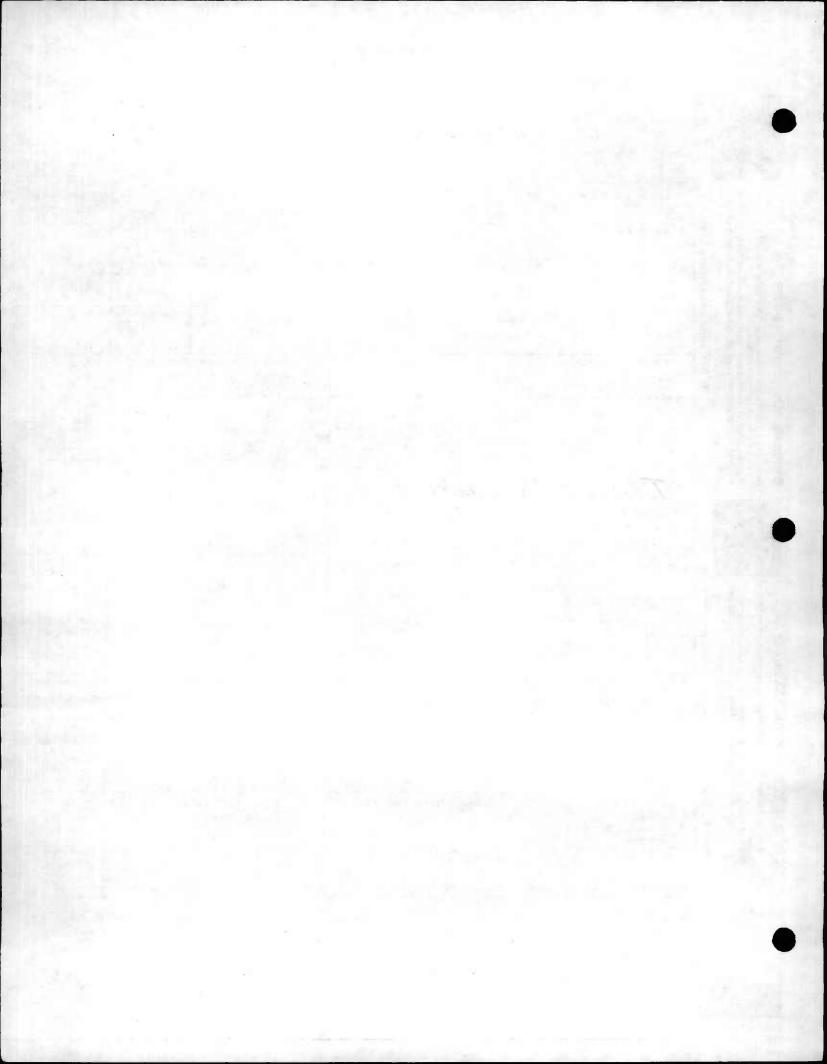
					Certifica		Death	Я	eg. No.	19880
	Physician	Decedent's Name (First, Middle, L.						2. Date of Dea Month	Day Y	3. Time of Death
9	/Medical	Tamara B.	Kaszkur	ewicz				April :	28,2000	12:45 P.M
\mathbb{N}	Examiner	4e Facility Name (If not Institution, g	ive street end number)				4b. City, Town, or Lo	ocation of Death	4c. County of	Death
10 V		5101 River Ro	ad Apt. #	915			Bethesd	a	Mont	gomery
,	Funeral Director		Sex 7. Ag	ge (In yrs. lest b 88	vrs. If Und Months	ar 1 Yaar Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day Jan. 28	3,1912	Birthpleca (Steta or Foreign Country), Russia
9		Usuel Residence of Decedent				-				
ylan	0 11	10a. State 10b. County		10c. City, Tov	wn or Location					10d. toside City Limits
. &	be notified Director	MD Montgo	mery		Bethesda	ı				1 ☐ Yes 2 □XNo
t t	ire 528	10e. Street and Number			10f. Z	ip Code			log. Citizen of Wh	
Wit	- E	5101 River Ro	ad Apt. #	915	500	208	16		United Amer	States of
deat	1	11. Marital Status	12. Was Decedent Armed Forces		13. Was Dec	edent of I	dispanic Origin? (Sp en, Mexican, Puerto	ecify Yas or No-		Amarican Indian,
Maryland 21213-0020 nd 2 should be filed within 72 hours after death with the Maryland	al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	No	If Yes, sp 1 ☐ Yes			Rican, etc.)	Black, Specify:	White, etc. White
2 2	natural', potent Exc	15. Decedent's	ducation	168	a. Decedent's Us	uel Occuj	pation		16b. Kind of Busi	ness/Industry
7 is	ygiane. her than "natura ft, the Medical Completed	(Specify only highest g	rade completed) College (1-4or	5.1	(Give kind of wallife. DO NOT	vork done use retire	duning most of work d)	ing		
1 within	iane. The M	Ciententally/Secondary (0°12)	5+	Pr	ofessor	Lang	oreign uage		Education	on
D ≡	other vent, be Cc	17. Fathar's Nama (First, Middle, Las	(1)				18. Mother's Nam	e (First, Middla,	Maidan Sumame)	
E 5	cev cev	Ivan Barance	wicz				Anna	Sobcz	vnski	
aryla	D M	19e. Informant's Name/Relationship		10	h Mailina Addra	ee /Stroo	and Number or Rur	•		Pete Zin Code)
2 2 5 6 4 2 5	7 le trau	Victor Potopov/			Carl Control of the		reet, N.W			
g . g	Health Other tr	20a. Method of Disposition	TITCHU					Date	20c. Location - C	
Saltimore,	Department of Health and Mental Hygia Important: If them 27 is marked other the eny injury or other traumatic event, the binds. To Be Col	20a. Method of Disposition 20a. Method of Disposition 20a. Method of Disposition 3	Removel from State	cemete	of Disposition (N ery, cremetory or	other ple		7/3	200. LOCATION - C	ity or Town, State
P. P.	ant:	4 Donetion 5 Other (Spec	ify)	Rock	Creek (gton, D.C.
שׁ שׁ	Departm importer eny injur	21. Signature of Juneral Septice Lice	ensee		22. Nama	and Addre	iss of Facility Hin	es-Rina	ldi FUne:	ral Home, Inc.
D 8	SESS	N Voulx	my S							pring, MD 2090
		23a Part1 Enter the disease or co	nolications that cause	d the death. Do	and the second					Approximata
9		23a. Part1. Enter the digaesa, or conshock, or heart failure. List only	y one cetse on each I	ine.						Intervel Between Onset and Death
	nysician Medical	Immediate Couse (Final				_				
	xaminer	disease or condition resulting in deeth)	aAcut	e myoca	rdial in	itarc	tion			immediate
	2000		7 100		consequenca o					
70	i e		Coro	nary ar	tery dis	sease				3 yrs.
ob/ou, tificate be executed	g physician and as the bunkl-transit	Sequentially list conditions,		Due to (or as a	consequenca of):	11-1			
5 §	List C	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events								
ficate be ex	he b	that initieted events rasulting in death) Last	C	Due to (or as a	consequence of):				
i i	O1 00 -									1
BOX aath cert	usa visa		d							1
the death cer	signed by the attending to be detached for usa a detached for usa a detached for usa a detached by Physician/M	Part II. Other significant conditions	contribution to death t	out not resulting	in the underlying	Cause oi	ven in Part I	23h Did t	obacco use contr	ribute to the cause of death?
j at	y the	, at it. Other argument continuous	community to dodin's	out not readifying	in the andenying	oudae gi	VOITHTT GITT.			□ Probably 4⊠ Unknow
T ta	De de de							101	es ZLINO	- Froming 42 officion
necords,	signe d be d							24a. Was a	n autonsv	24b. Were autopsy tindings
5 8	been s should							perfor		available prior to completion of cause
E	npl									of death?
E #	cate has been s page 2 should Completed							1 U Y	es 2ENo	1 ☐ Yes 2 ☐ No
VIEN Siclen: T	certificate rector, pag	25. Was case referred to medical exeminer?					26. Plece of Deal	h (Check only or	78)	LIGHTER R. P.
	0 D	1 Yes 2 No	Hospitel: 1 ☐ Inpati	ent 2 ER/C	Outpatient 3 I	OOA Ot	her: 4 Nursing Ho	ome 5 Resid	ence 6 Other	(Specify)
P P	erthis leral d	27. Menner of Death	28e. Dete of Inju	iry 28b.	Time of	28c. tnju Wo	ry at	28d. Describe h	ow injury occurre	d.
OV Attending	is after death. ii Director: After the in by the funeral Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident invastigeti	(Month, Da	ty rear)	Injury M		Yes 2 No			
E S	octor by th	3 ☐ Suicida 6 ☐ Could not	250. Place of in	jury - At home, t	farm, street, fecto	ory, office				or Rurel Route Number,
5 8	Pin H	4 Homicide	building, e	(c. (Specify)				City or Tow	n, Stete)	
Hospital	within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral Medical Certification: 1		hysician: To the best miner: On the basis of	f examinetion e						
\$	thin of the mple	29b. Signature and title of certifier	and menner st	a180.	0	9c Linen	se number		29d Date signed	(Month, Day, Year)
2		250. Signapare and title of certifler	911	15	14 4	A -				
	5	No ge	11/81	16/	100	0-	1935	3	May 3,2	000
		30. Name and address of person who George Graves) (Type, Print) consin A	ve.	#925 Che	vy Chas	e,MD 20	815
	State	31. Date filed (Month, Day, Year)		rar's Signature	1	,				
	Registrar	MAY 04	2000	wa	19. de	souk	2			



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State of Maryland / Department of Health and Mental Hygiene 1588

		Ce	rtificate of	Death		Reg. No.		
1. Decedent's Name (First, Mic	ldle, Last)				2. Dete of De	ath	Veer	3. Time of Death
dical	LAWRENC	E A. KE	IL		MAY	Dey 2	Year 000	3:50 P.M.
4a Facility Name (If not institut	ion, give street and number) 'E ADVENTIST	HOSPITA	ĄL	4b. City, Town ROCKV	n, or Location of Deat	4c. County MONT	-	RY .
5. Social Security Number 360–20–7537	AMM ADE	(In yrs. last birthday,	If Under 1 Yea Months Day		Min. 8. Dete of Bir (Month, De JUNE 20	th ly, Year) 1928	Cour	plece (State or Foreign ntry) INOIS
Usual Residence of Decedent 10a. State 10b. Coun	hv I	10c. City, Town or L	ocation					I0d. Inside City Limits
340	LOUIS	Too. Oily, Town or E	VALL	EY PARK				1 ☑ Yes 2 ☐ No
MO ST. 10e. Street and Number 145 INVERNESS 11. Marital Status 1 Never Merried 25 M.			10f. Zip Code	63088	3	10g. Citizen of	Whet Cour	ntry?
11. Marital Status 1 □ Never Merried 2 ☑ Mr. 3 □ Widowed 4 □ Divorce	If Yes Give		Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		n? (Specify Yes or No Puerto Rican, etc.)	Specify	ck, White,	can Indian, etc. JHITE
15. Decede	ent's Education nest grade completed)	16a. Dece	edent's Usual Occ	upation e during most o	of working	16b. Kind of B	usiness/In	dustry
Elementary/Secondary (0-12	College (1-4or 5-	F)	b kind of work don DO NOT use retii	ed)				
17. Father's Name (First, Middl	4	CL	ERGYMAN	10 Methods	s Neme (First, Middle	LUTHERA	-	URCH
EDWIN KEIL				ADEL	INE STELK		Ť.	
19a. Informant's Name/Relatio					or Aural Route Numb			Code)
MARILYN KEIL 20a. Method of Disposition	- WIFE	20b. Place of Disp	INVERNESS	o VAI	LLEY PARK,	MO 6	3088	oun State
	a 3 □Removel from State (Specify)		ematory or other p		5/5/00		-	ISSOURI
21. Signature of Funeral Service	De Licensee	2 0	2. Name and Add		JOSEPH GAWASHINGTON			116
23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caused					•	200	Approximate
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Oue to (or es a conse						
Part IL Other significant condi	d	t not reculting in the	mdarhéna enues e	ikan in Past I	22h Did	tobacco use co	ntribute t	o the cause of death'
	ATORY IN			Men in Pett I.		Yes 2 No		bably 4 Unknow
	TION PNO				24a. Wes	en eutopsy ormed?	av	ere eutopsy findings allable prior to empletion of cause deeth?
					10	Yes 2K No	1[□Yes 2□ No
A S PI R A 7	al			26. Place o	Deeth (Check only	one)		
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3 ☐ Suicide 6 ☐ Coul	d not be mined 28e. Place of Injur- building, etc.	ry - At home, ferm, st (Specify)	reet, fectory, office	9		Street and Numb wn, State)	ber or Rura	al Route Number,
27. Manner of Death 1 Natural 5 Pend invest 2 Accident 3 Suicide 6 Coult 4 Homicide 29a. Certifier (Check only 2 Mandata)	ing Physician: To the best of a Examiner: On the basis of and menner stet	examinetion and/or in	th occurred at the ovestigation, in my	time, date and popinion, deeth	place, end due to the occurred et the time,	cause(s) and madate end plece,	anner as s and due to	stated. the ceuse(s)
29b. Signature and title of certif			29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)
		CIAN		23/77		5/2/2	000	
30. Name and address of person MARIO 0.	n who completed cause of de $BELLEDONNE$			16 KESSI	ronge LI	V 205	ROC	KVILLE
31. Date filed (Month, Day, Yea	T	_	1					



	0-2451-03 LENNON	Please	Type or Prin	nt In Black aryland / D						ble.	282
K	ENNEDY JE	₹.			Certifica	te of L	Death		Reg. No.	10	006.
	Physician /Medical	1. Decedent's Name (First, Middle, La GLENNON ANTHO		NNEDY,	JR.			2. Date of Do Month MAY	Day 2, 20	Year	3. Time of Death 2:10P.M.
	Examiner	4a Facility Name (If not institution, gir	e street and number)			4	b. City, Town, o	Location of Deal			
-	Funeral		Sex 7. Ag	ge (In yrs. last birti	nday) If Undo	er 1 Year	ONTGOMEI	s. 8. Date of Bi	GE MONTG		e (State or Foreign
п	Director	495-24-5822	1 M 2 F	71	rs.	50,0			0, 1929	Monta	
	hours etter deeth with the Maryland hural; or Herne 23e or 23e-f show at Exampler must be notified at ad by Funeral Director	Usuat Residence of Decedent 10a. State 10b. County Maryland Montgot	nery	10c. City, Town	omery V		ge				Inside City Limits 1 ☐ Yes 2 ☐ No
	with II	10e. Street end Number 19433 Battleridge	a Man		10f. Z	ip Code 208	86		10g. Citizen of \		7
	ne 23	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dec			Specify Yes or N	United	States e - American	Indien,
020	urs efter deeth version of the second	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces?	No 7/51-	144	ecify Cuba 2⊠No		Specify Yes or N rto Rican, etc.)	Specify	ck, White, etc.	
21215-0020	within 72 ane. than "net he Medic	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	Decedent's Us (Give kind of w life. DO NOT Analyst	ork done d use retired	ation furing most of w	orking -	16b. Kind of B	usiness/Indust	
	Hygin ent, per Co	17. Father's Name (First, Middle, Last			illaryse		18. Mother's Na	ame (First, Middle	e, Maiden Surnam		
Maryiand	Mental H Mental H arked oth atic even	Glennon Anthony	Kennedy,	Sr.			Margai	ret	Duff	У	
any	d 2 should th end Mer ? Is marks traumatic	19a. Informant's Name/Relationship	-		Mailing Addres	s (Street			ber, City or Town,	Stete, Zip Co	de)
	tem 27 i	Patrick A. Kenned	dy, Broth				ge Dr,	lefferso	n City,	MO 65	109
Baltimore	Peges ent of mt: H th	20a. Method of Disposition 1 Burial 2 Cremation 3 E 4 Donation 5 Other (Speci		comotor	Disposition (Na v, crematory or Heave	other plac		May 8, 2000	20c. Location -		
Balt	permit. Departm Importal any inju	21. Signature of Funeral Service Lice	Hu				ss of Facility Park Di		uneral H hersburg		20877
	Physician /Medical	23a. Pert Enter the disease or conshock or heert failure/ tist only Immediate Cause (Final disease or condition	pplications that cause one ceuse on each to	d the deeth. Do nine.	ot enter the mo	.n			arrest,	Int	pproximate lerval Between nset and Death
	Examiner	resulting in death)	1 Ca	Due to (or as a c	consequence of):	Dis cos	e			
	en and inal-transit Examine	Sequentially list conditions, if any, leeding to immediate	-	Due to (or es e c	onsequenca of):					
68760	0 0 5	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a co	onsequence of):					
Box	th cer tendir or use		d							1	
P.O.	by the tached	Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying	cause giv	en in Part I.			ntribute to th	e cause of death?
Records,	The law requires that the law been signed page 2 should be de Completed by F	Chroric A	Fluholis	m					s en eutopsy formed?	eveila	eutopsy findings ible prior to letion of cause eth?
	The la							100	Yes 2□No	Arr	es 2□ No
Vital	ystclan: The secretificate director, per	25. Was case referred to medical examiner?					26. Place of D	eeth (Check only	one)		
of V	7 8 D	1 TYes 2 □ No	Hospital: 1 Inpati		patient 3 [4 U Nursing	1	sidence 6 Oth		
	r death. ector: After th by the funerel	27. Manner of Death Neturet 5 Pending investigation			ime of njury M	28c. tnjun Wor 1 🗆	y at k? Yes 2 □ No	28d. Describe	how injury occur	red	
Division	plat or Attending P purs after death. Prail Director: After t filled in by the funer il Certification:	3 Suicide 6 Could not 8 4 Homicide determined	28e. Placa of In	jury - At home, fai lc. <i>(Specify)</i>	m, street, fecto	ery, office			(Street and Numi own, Stete)	ber or Rural R	oute Number,
	do a	29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowledge.	deeth occurre	d at the tin	ne, date and pla	e, and due to the	e cause(s) and m.	anner es state	ed.

To the Hoa within 24 hc To the Fund completely it

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

111

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

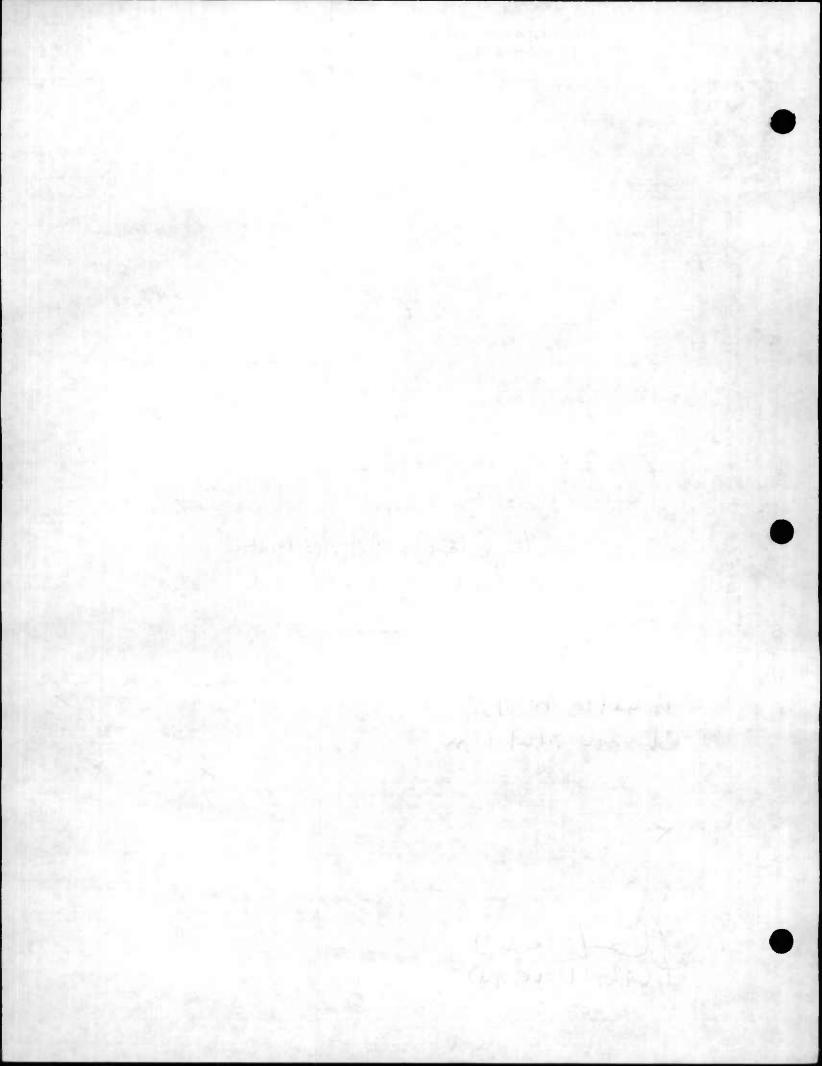
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

> MAY 3,2000 O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

State Registrar

MAY 05 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death May Khoury Mark 2000 6:56 AM 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Prince Hospital Regional Laurel George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 21, 1950 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign XXM 20 F Palestine 212-78-5257 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Prince George's Laurel 1 Yes XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? United States 20707 7605 Woodruff Court 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: 1 ☐ Never Married XX Married White 1 Yes 2XXNo Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Mechanic Private 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Adib Khoury Kamleh Obeid 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8723 Baltimore St. Savage, Maryland Ben Khoury (Brother) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 Cremetion 3 Removel from State Md. National Mem. Park 5/5/2000 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafore of Funerei Service Licen 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximate Interval Between Onset end Death

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mentel Hyglene. Important: if tem 27 is marked other than "natural", or flems 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at any linjury or other traumatic event, the Medical Examiner must be notified at any linjury or other traumatic event, the Medical Examiner must be notified at any linjury or other traumatic event.

altimore, Maryland 21215-0020

the Marylend

/Medical

Director

Funeral

by

Completed

Be

20

Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

slcien end burial-transit ettending physicien for use as the buna Physician/Medical been signed by the should be detached þ Completed s certificate hes t director, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it Be Certification: To edical

25. Wes case referred to medical

1 Yes 2 No

Hospital:

examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as e consequence 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Was an autopsy performed?

1 Linpatient 2 ER/Outpetient 3 DOA

28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and menner as stated.

| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and menner stelled. 29e. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of pentile 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) HARMINDER 303, SOW EDMONSTON DR, ROCKVILLE S. SETHI 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture

1□ Yes 2 No

28d. Describe how injury occurred

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 XNo

State Registrar

Author Programme 125 (1972)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 3:55 pm May 1, 2000 Rosa Lee Kohl /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Rehabilitation and Nursing Ctr. Burtonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplaca (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Months Yrs. June 4, 233-36-7325 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ehow. I be filed within 72 hours after death with the Meryle ntel Hyglene. conduct than "netural", or items 23a or 28a-1 show and other than "netural", or items 23a or 28a-1 show swart, the Medical Earth has made to be not a contract. 1 ☐ Yas 2 ☐ No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2417 Nees Lane 20905 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 21215-0020 If Yes, Give Year or Dates: 1 Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TATA Data Clerk Maryland permit. Pages 1 and 2 should be file Department of Heelith and Mentel Hy Important: If flem 27 is marked other any injury or other traumatic event DOGS. 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Clay Clayton Coe Mary Workman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2417 Nees Lane, Silver Spring, MD John_W. Kohl/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 5/4/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Nama and Address of Facility
Francis J. Collins Funeral Home, Inc. Leu Slive 500 University Blvd., W, Silver Spring, MD 20901 Approximate Injerval Between Onsel and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final a Metastatic Breast Cancer diseese or condition resulting in death) l year Examiner Due to (or as a consequence of): Examiner ician and bunal-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or es a consequenca of): 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably ♣ Unknown Stroke Records, Sign De þ 24b. Were autopsy findings available prior to been si 24a. Wes an autopsy Completed complation of cause of death? page 2 s hes 1 Yes 2 No 1 Yes 2 No of Vital Physicien: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Oulpatient 3 DOA After this funerel 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Division or Attending 1X Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide edical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie May 2, 2000 an D 43237 20 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) Paul Armstrong, MD 14201 Laurel Park Drive, Suite 102, Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

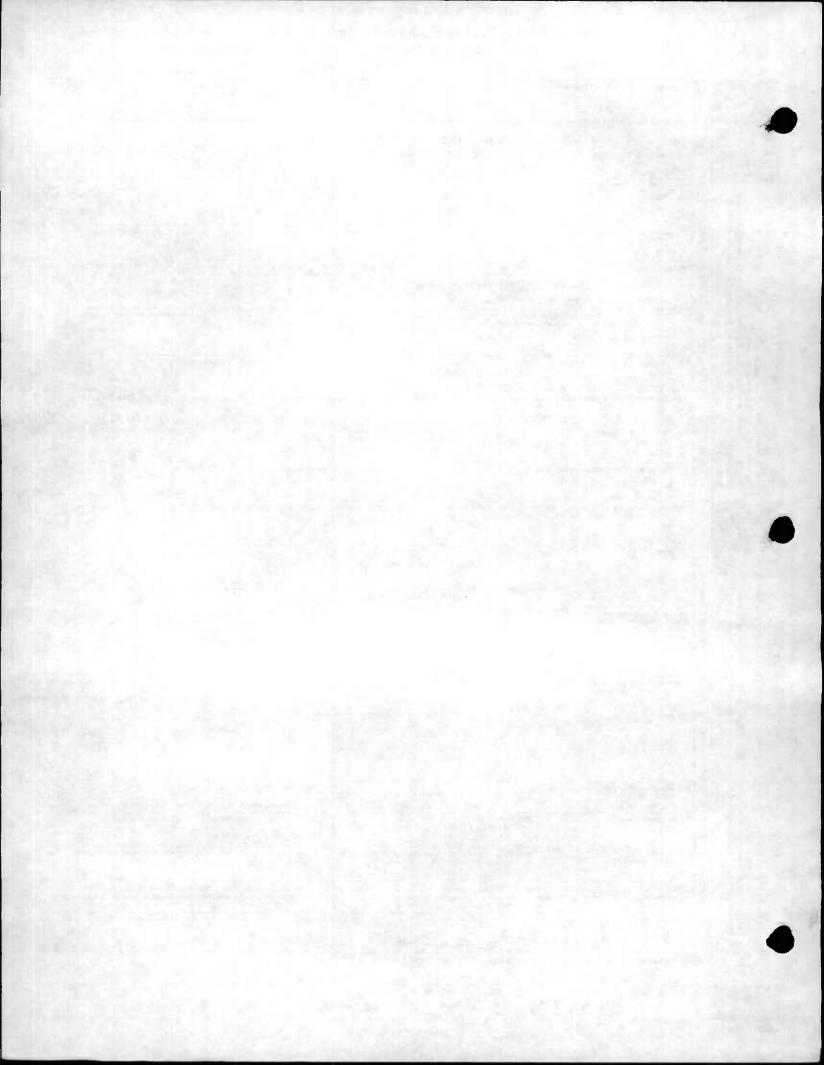
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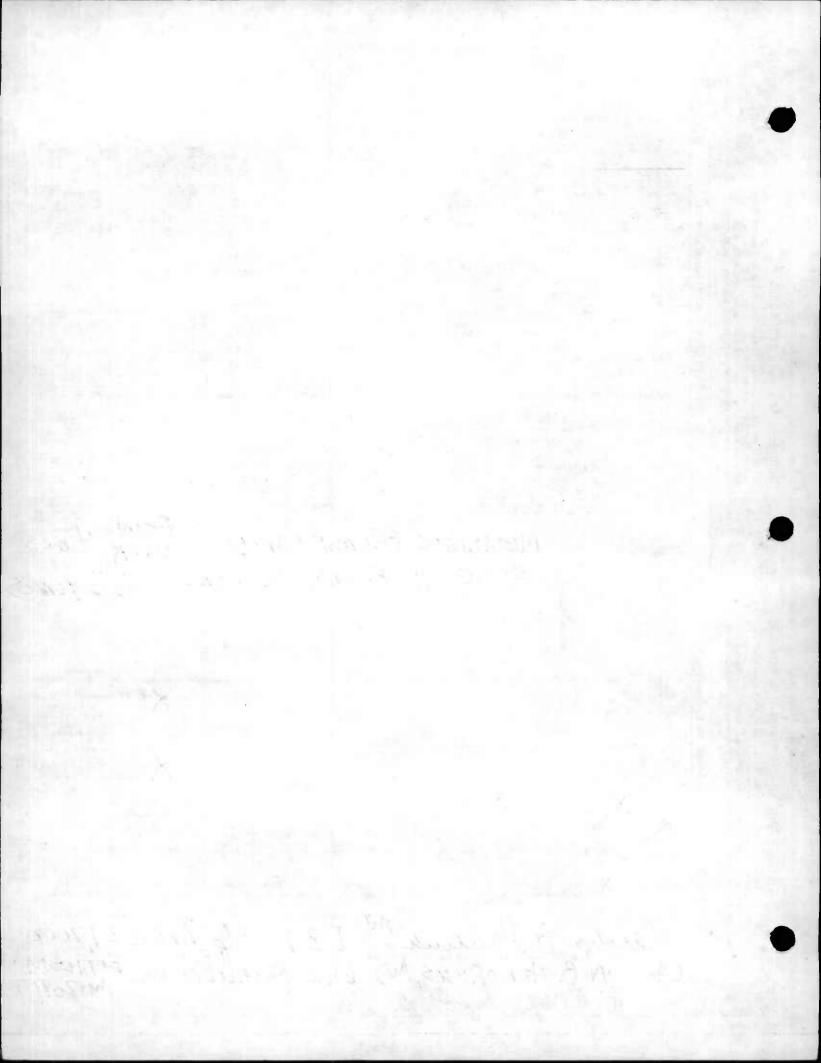
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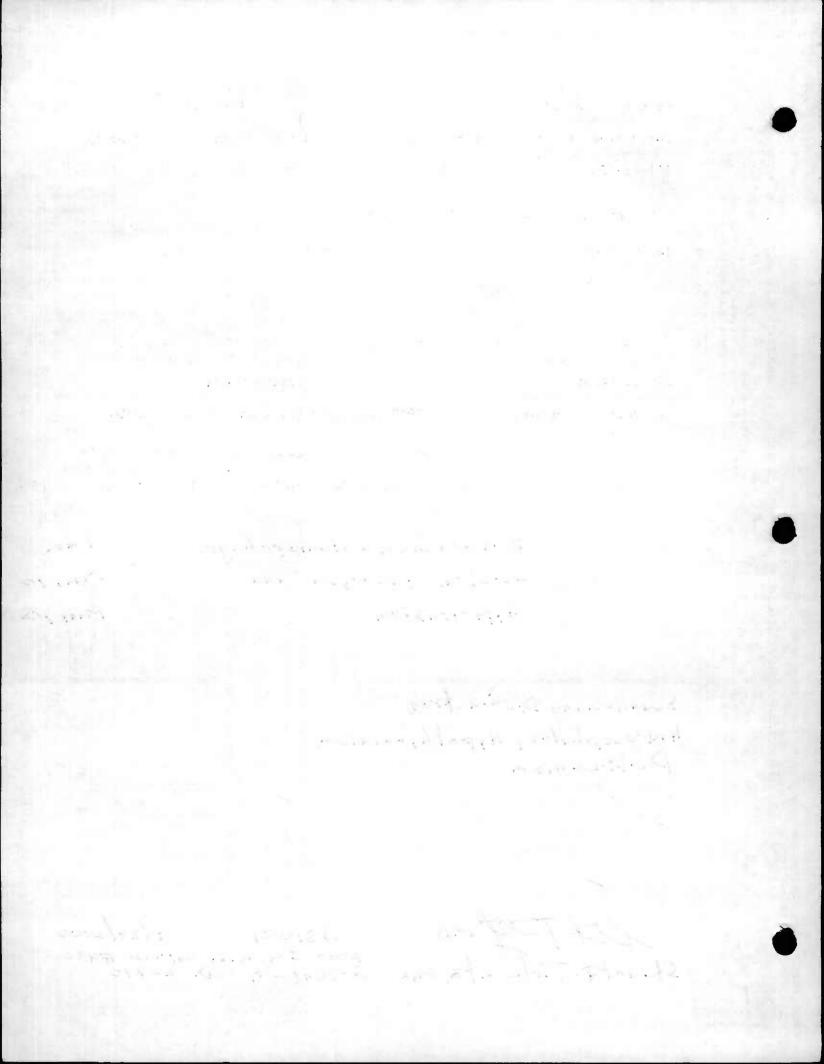
AM	ENDED ITEM	#5 PER FH G785 7		AH	Marylar		rtificate of	Health and N Death		leg. No.	5	885
П	Physician	1. Decedent's Name (First							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medical	Alicia			A = = 3			4b. City, Town, or L	April 2		10	10:15 AM
	Examiner	4a Facility Name (If not in Suburba			Der)			Bethesda		4c. County o		
	Funeral Director	5. Social Security Number 097-32-8031 - 097-30-8031			7. Age (In yrs. 59	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt	Mont; 7, 1940	9. Birthpl	lace (State or Foreign
	b .	Usual Residence of Deced	dent County		10- 0	y, Town or Lo						
	with the Maryland a or 28s-1 show Libe notified at						ACRETON 1				"	0d. Inside City Limits
	vith the Ma	Maryland M	ontgon	nery	Po	tomac	10f. Zip Code			10g. Citizen of W	net Coun	
	23a or	12213 Meadow	Crook	Court				854				
	fler death v r flems 23 flor must Funeral	11. Marital Status	Orcer	12. Was Deced	Sent Ever in U	,S. 13.	1	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	United 14. Race	- Americ	an Indian,
Maryland 21215-0020	by by	1 Never Married 2 3 Widowed 4 Di	-	Armed Ford 1 Tes If Yes, Give Year or Da	2 ⊠ No		If Yes, specify Cub		o Rican, etc.)	Specify:	, White, o Wh	etc. .ite
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121	ed within 72 hoygiene.	Elementary/Secondary		College (1-	4or 5+)	life.		during most of work d)	9	Public		vate
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and	Mental H mrked out artic ever	17. Fether's Neme (First, I Anthony Cass	The state of					18. Mother's Nem		Maiden Sumame)	
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a)	Department of Heelth and Mental Hygintheortant: if Item 27 is marked other any injury or other traumatic event, ands.	20a. Method of Disposition		uspand	20b. F	Plece of Dispo	sition (Name of	Creek Cou	Date	omac, Mai 20c. Location - C		
Baltimore,	pemit. Peges Department of H Important: If Ne any injury or of page.	1 Donation 5 0			tate		metory or other pla	IT.	flay 1,	0-1	NY	371
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s, P.0	5 60								10'	No No	3 □ Prot	bebly 4 Unknown
Record	aw requisite been 2 should plete								24a. Wes perfo	an autopsy med?	800	ore autopsy findings ailable prior to mpletion of cause death?
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Vital	s certificate director, pag	25. Was case referred to reaxaminer?						26. Place of Dea	th (Check only o	ne)		
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Ž.	After thi funeral flon: T		Pending	28a. Dete of (Month	tnjury Day Year)	28b. Time or Injury	Wo		28d. Describe t	ow injury occurre	d	
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)i	or A Direction by	4 Homicide	determined	building	g, etc. (Specif	y)	reet, factory, office		City or Tox		r or riora	riodie Number,
_	Hospi 4 hou Funer laly fill	29a. Certifier 12 Co (Check only 2 Me	ertifying Phy edical Exam	sician: To the b	ils of examina	wledge, death	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occur	and due to the ored et the time, or	cause(s) and man date and place, a	ner as st nd due to	ated. the cause(s)
	To the To the compla	200. Signature and title of	certifier	11			M)9c. Licens	se number	71	29d. Date signed	(Month, i	Day, Year)
J	20	arole	NI) HE	udu	ele	, TU	512	261	HKIL	. 6	1,000
		30. Name and address of	2 who c	ompleted cause	of death (Item	23a) (Type,	Print)	1 - D	#30	5	BE	THISTA
		31. Date tiled (Month, Dey,	Year)	15 VD	KICH	2,14) 64	10 100	KUEVC	E DR.	1	カク・リノ
	State Registrar	MAY		100	grottal S Signs	S.	Spar	2			15	1 1800 0



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'e Neme (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** April 28, Arthur L. LaPoint 6:15 AM 2000 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Silver Spring Springbrook Adventist Nursing Home Montgomery If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year Birthplaca (Stata or Foraign Country) **Funeral** 11XM 2□ F Months Davs Director 441-05-7500 Mar 12, 1912 Michigan Usual Rasidance of Decedant with the Maryland 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Moultal Examiner must be notified at 1 ☐ Yas 2 H No Director Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 14708 Lindsey Ln death v Funeral 20906 USA Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedent Ever in U,S Armed Forcas? 11. Marital Status 14. Race - Amarican Indien, Biack, Whita, atc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural, or Item any follury or other thaumatic event, the Medical Energies any follury or other thaumatic event, the Medical Energies. 1 ☐ Yas 2 ☐ No If Yas, Give 1 ☐ Nevar Married 2 ☑ Married Maryland 21215-0020 1 Yas ∑ No Specify: q Specify. 3 Widowed 4 Divorced White 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) Examiner Patents 17. Fathar's Name (First, Middle, Last) 18. Mothar'a Nama (First, Middla, Maidan Sumama) Be Jay C. LaPoint 2 Martha Young 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1917 Wakefield St, Alexandria, VA 22308 Ann Perkins/Daughter altimore. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) Fort Lincoln Crematory May 2 Brentwood, MD 21. Signature of Funeral Sarvice Licensaa 22. Nema and Address of Fecility Hines-Rinaldi Funeral Home 000 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the diseasa, o complications thei caused tha daath. Do not antar the mode of dying, such es cardiec or raspiretory errast, shock, or haart failura. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final Subarachnoid disaasa or condition rasulting in daath) **Examiner** Examiner Aneurysm Gerebral physician and s the burial-transit requires that the death certificate be executed Sequantially list conditions, if eny, laading to immediate cause. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in daeth) Lest Hypertension P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): USB BS attending plor use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à rocephalus, Hypothyroidism 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has Parkinsonism 1 Yas 2 No 1 ☐ Yas 2 ☐ No cartificate Attending Physician: funeral director. 25. Wes casa rafarred to medical axaminar? Be 28. Pleca of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deatl 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding s after death. investigation 1 Yes 2 No 2 Accident 6 Could not be datarminad 3 Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida ò 24 hours Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartiflar To the Hosp within 24 hor To the Fune completaly fi Medical (Check only one) 29b. Signature any 29c. Licensa number 29d. Data signed (Month/Day, Year) 4/28/2000 U31001 C use of dyath (Itam 23a) (Type, Print) 7500 6 reenway Catr. Dr. #430 Greenbelt, MD. 3 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State 02 2000 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 2, **Physician** 2000 8:30 AM Pauline A. Latsey /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Bethesda Suburban Hospital Maryland If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month Dey, Year) July 14, 5. Sociel Security Number 9. Birthplece (State or Foreign 1915 County) 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1 ■ M 2 🗓 F 021-03-2782 84 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Bethesda 1 Yes 2 No Director r 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20817 8317 Tomblinson Avenue USA 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus al Hygiene.
I other than "natural", or lier
vent, the Medical Examiner. 1 □ Never Merried 2 □ Merried 1 ☐ Yes 2 ☑ No If Yes, Give A Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ğ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working iile. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is merited other any Injury or other traumetic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Unknown Prifty Magdalene Apostols 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Christine J. Latsey - Daughter 8317 Tomblinson Avenue Bethesda, MD 20817 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 5/8/00 Cambridge, MA Mt. Auburn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility
Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, 23a art. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical day Examiner Due to (or as e consequence of) Examiner ferated bowe bunal-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): attending physician I for use as tha buris obstration Severe Physician/Medical Due to (or es e consequence of): tate has been signed by the a page 2 should be detached to Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à Completed 24b. Were eutopsy findings avellable prior to completion of cause of death? 24e. Wes en eutopsy performed? certificate has 1 Yes 2 And 1 ☐ Yes 2 ☐ No funeral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer Attanding 5 Pending 1 Neturel Ne Hospital or Attanding in 24 hours after death. The Funeral Director: After 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, term, street, tectory, offica building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) within 2. To the F \$ 29c. License number 29d. Date signed (Month, Day, Year)

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29b. Signeture end title of certifies

32. Registrer's Signeture

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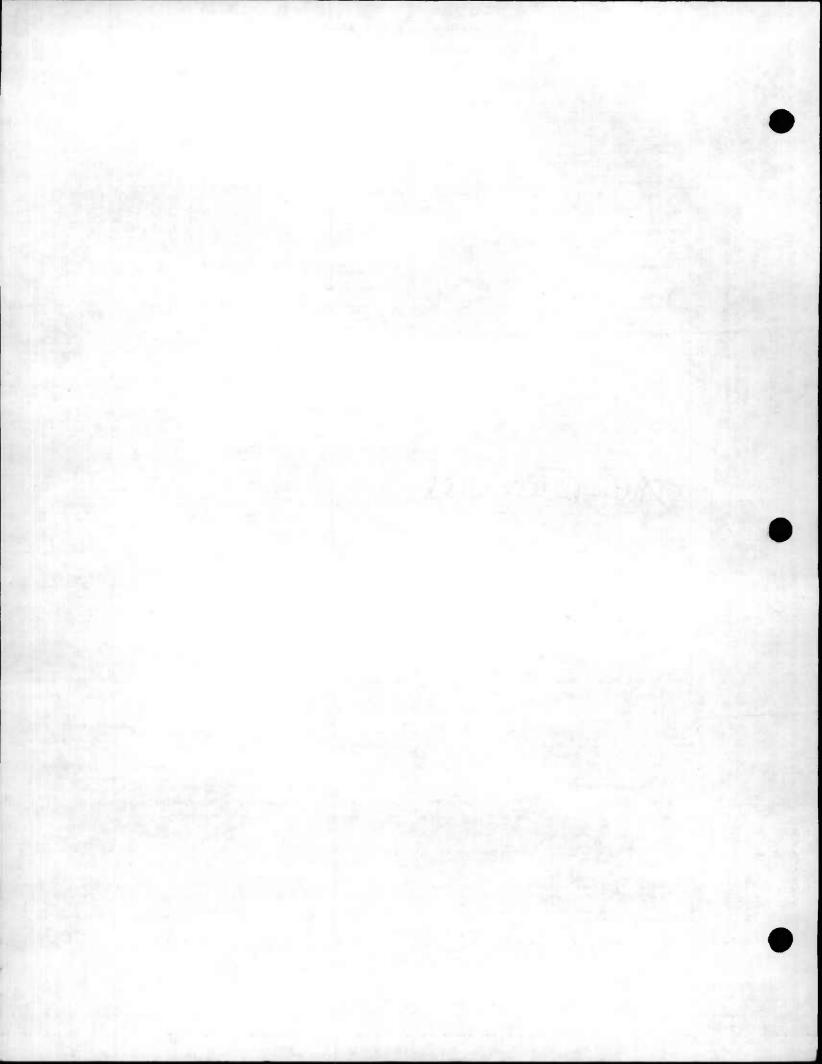
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)
Nancy P. Lawless, MD 8600 Old Georgetown Road Bethesda, MD 20814

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8:30AH

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician 30, 2000 April 5:15 pm Beatrice E. /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth **Examiner** Holy Cross Rehabilitation and Nursing Ctr. Burtonsville
| If Undar 24 Hrs. | 8. Date Montgomery 8. Date of Birth (Month, Dey, Aug 23, Birthplece (State or Foreign Country) 5. Societ Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 TAF Deys 80 Yrs. Aug Director 182-16-5780 Pennsylvania Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Opertment of Health and Mental Hyglene. Important I farm 23 e or 28e-f show Important I farm 27 ie marked other than "natural", or florms 23e or 28e-f show any injury or other traumfic event, the section Example must be notified. 28a-f show 1 X Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8811 Colesville Road # 402 20910 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Baca - American Indian Bleck, White, etc. 1 X Nevar Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Budget Analyst Federal Government 17. Fsthar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 10 Magaret Condran Patrick Leary 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8811 Colesville Road #402, Silver Spring, MD 20910 and Disposition (Name of Date 20c. Location - City or Town, Stata Rose Leary / Sister 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State Gate of Heaven Cemetery 5/3/00 Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
Francis J. Collins Funeral Home, Inc. 21. Signatura of Funarai Sarvice Licensee 500 University Blvd., W, Silver Spring, MD 20901 Approximete Intervel Between Onset and Death 23e. Pert1. Enter the disease, or complications that clusted the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each one. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) a Stroke 1 week Examiner Dua to (or as a consequence of): Examiner Myocardial Infarction 2 weeks The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immadiate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): Box 68760, Giant cell arteritis 1 year Physician/Medical the Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part t. P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus type 2 þ Records, 24b. Were autopsy tindings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? has 1 ☐ Yes 2 ZNo 1 ☐ Yas 2 No certificate of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 5 Pending investigation 1 Neturat 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 \ Homicide To the Hospital o within 24 hours at To the Funeral D W Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basts of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier completaly (Check only one) 29b. Signatyre and title of captifier 29c. License number 29d. Data signed (Month, Day, Year) D 43237 May 1, 2000 10 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

32. Registrer's Signature

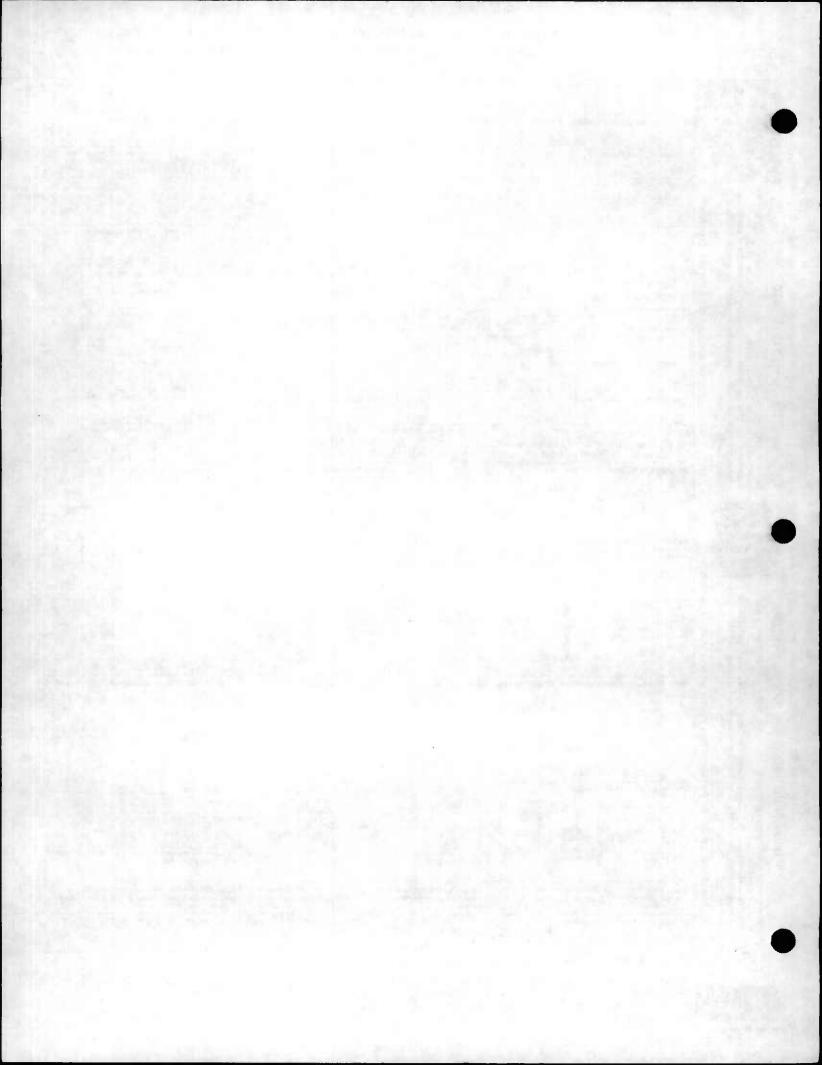
14201 Laurel Park Drive, Suite 102 Laurel, MD 20707

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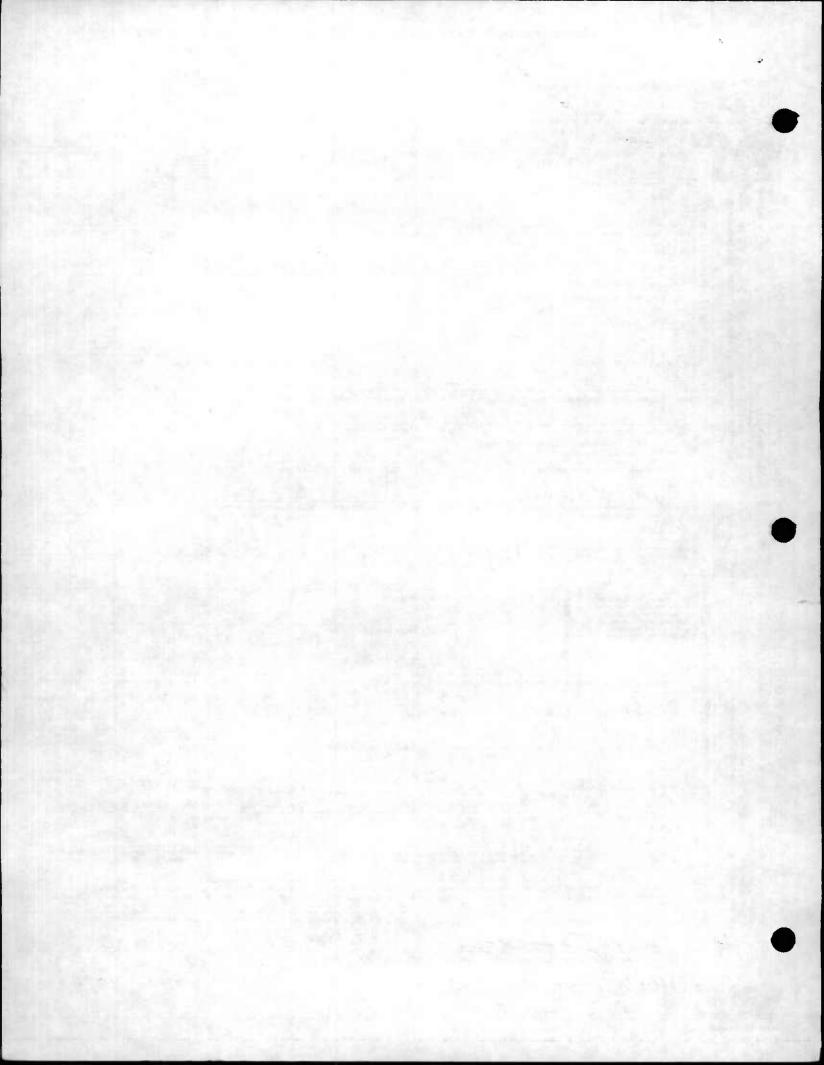
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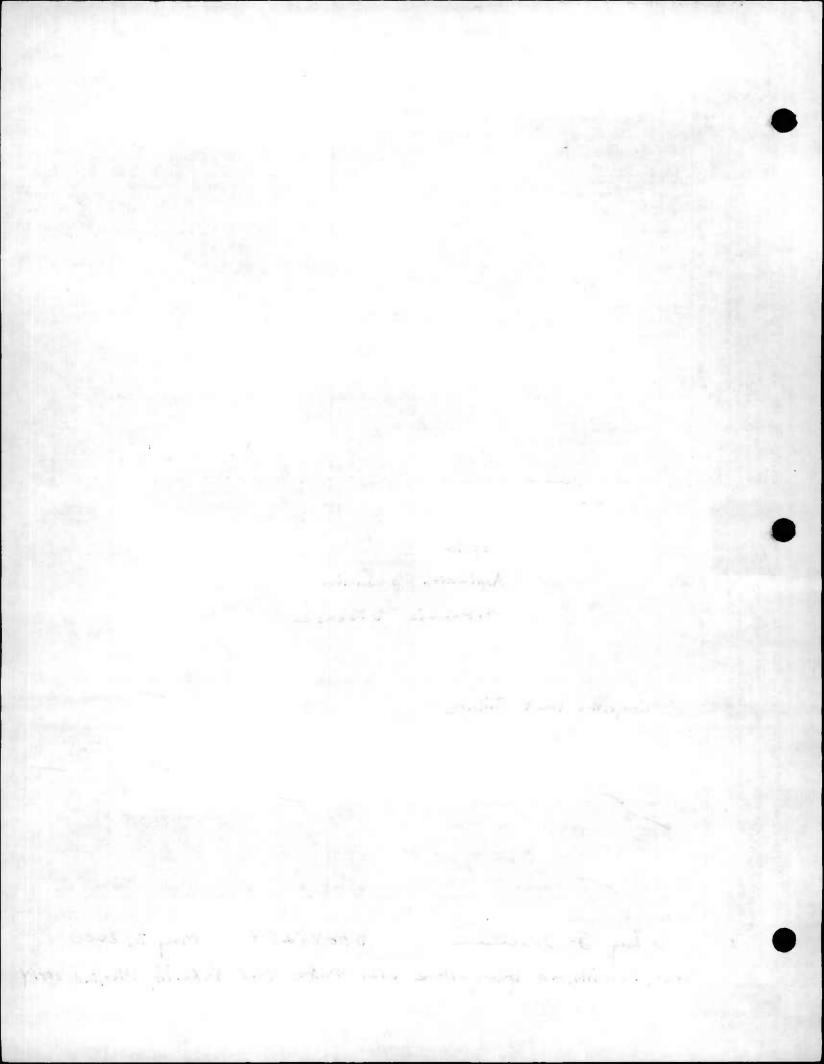
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s conflicate has been director, page 2 should be seen of the seen	Congestive	Heat For	ilure				Francisco.	10	Yee 25 No	3□ Prob	ably 4 Unkn
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25. Was continued on the control of								10	res 20 No	10	Yes 2□No
examile of the state of the sta	case referred to medic	al					26. Place of De	eth (Check only o	ne)		
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= 5 Nanna		28a. Date of	·	28b. Ti		28c. Inju Wo		T	now injury occurre		,
Directoo	Suicide 6 Could	d not be 28e. Place of	of Injury - At h g, etc. (Speci	nome, far	m, atreet, facto	ory, office		28f. Location (City or To	Street and Number vn, State)	er or Rura	l Route Number,
24 hours file of Chec one) 29a. Certification (Chec one)		ing Physician: To the bat Examiner: On the bas and manner	sis of examine	owledge, etion and	death occurre /or investigation	ed et the ti	ime, date end plac opinion, death occ	e, end due to the urred et the time,	cause(s) end med date end plece, e	nner es st end due to	ated. the ceuse(s)
29a. Certification of the complete of the comp	tifier 1 Certify		•		2	29c. Licens	se number		29d. Date signed	(Month, L	Day, Year)
	tifier 1 Certify					200	5525	8	Mar. 3	2.0	()00
7	tifier 1 Certify		,				3 - 5 - 3	•	May 3	, ,,	
Gara	idier 1 Certify pck only 2 Medica Mature end title of certifi	ier		m 22a) /	Type Print)					. 11	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #23a,5/2/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 30,2000ear **Physician** Jose D. Leyton 9:30pm /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number if Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) Date of Birth 9. Birthplece (State or Foreign API 12, 1906 on NA caragua **Funerai** Deys Months Hours 1 M 2 □ F 99 554-33-9854 Director Usual Residence of Decedent 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Prince George's MdRiverdale 1 Yes 2 No Director 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 20737 USA 5605 59th Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1⊠Yes 2□No Specify:Nicaraguan Specify: Hispanic þ 3 Widowed 4 Divorced Completed traumatic avent, the Medical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than any fujury or other traumatic avent, the Magnote. Elementery/Secondary (0-12) College (1-4or 5+) Electrician City of Managua 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ramirez Ruben Leyton 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5605 59th Avenue Riverdale, Md 20737 David Leyton/ Son 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removel from State 4/3/00 Laurel, Md Maryland National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PHILIP D.RINALDI FUNERAL SERVICE 11818 New Hampshire Ave. Silver Spring, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 months **Physician** Non Hodgkins lymphoma immediate Ceuse (Final disease or condition resulting In death) /Medical Examiner alun Due to (or as a consed Examiner attending physician and for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thei initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown milignent lymphoma þ 8 arebroviscular accident 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

certificate be executed Box 68760. P.O. Records, of Vital To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral Division

certificate has

this

Baltimore, Maryland 21215-0020

'natural', or

State

Medical

29a. Certifier (Check only

29b. Signature and title of certifier

admin soskal

Registrar

30 Name and address of person who completed co

29c. License number 046093

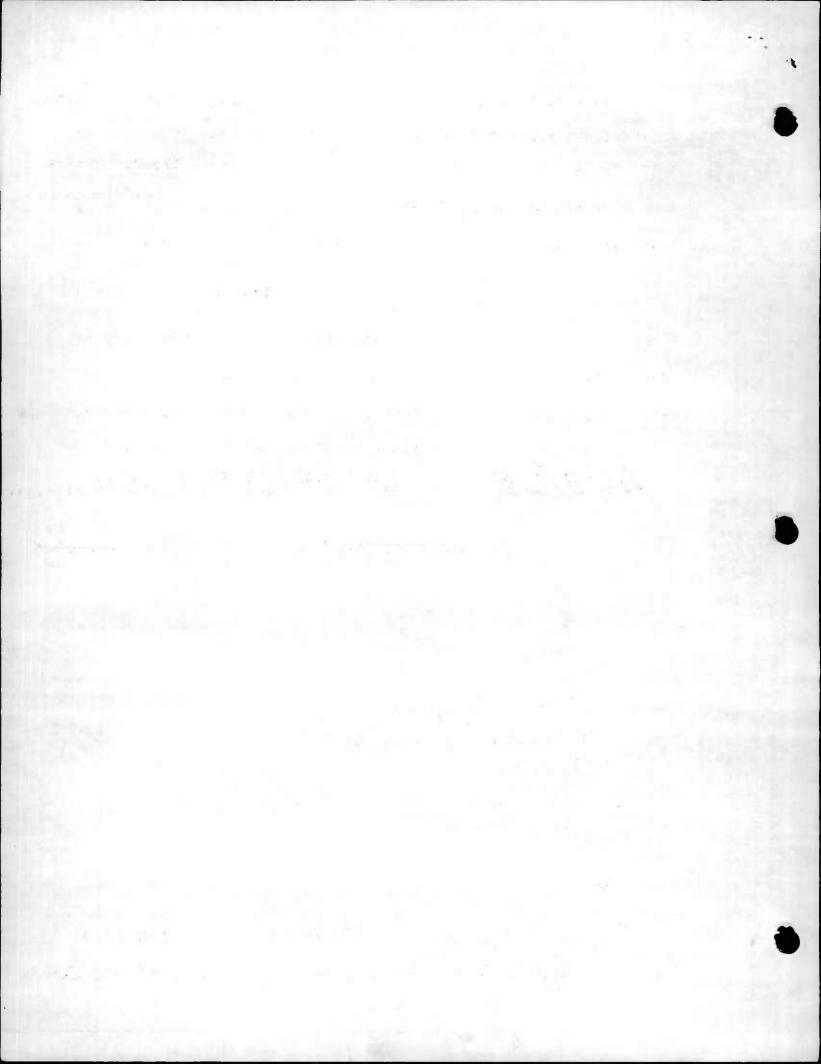
15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Yeer)

e of death (Item 23a) (Type, Print)

7-305 Hanover Parkway Grunbelt, MD 20770

32. Registrar's Signature

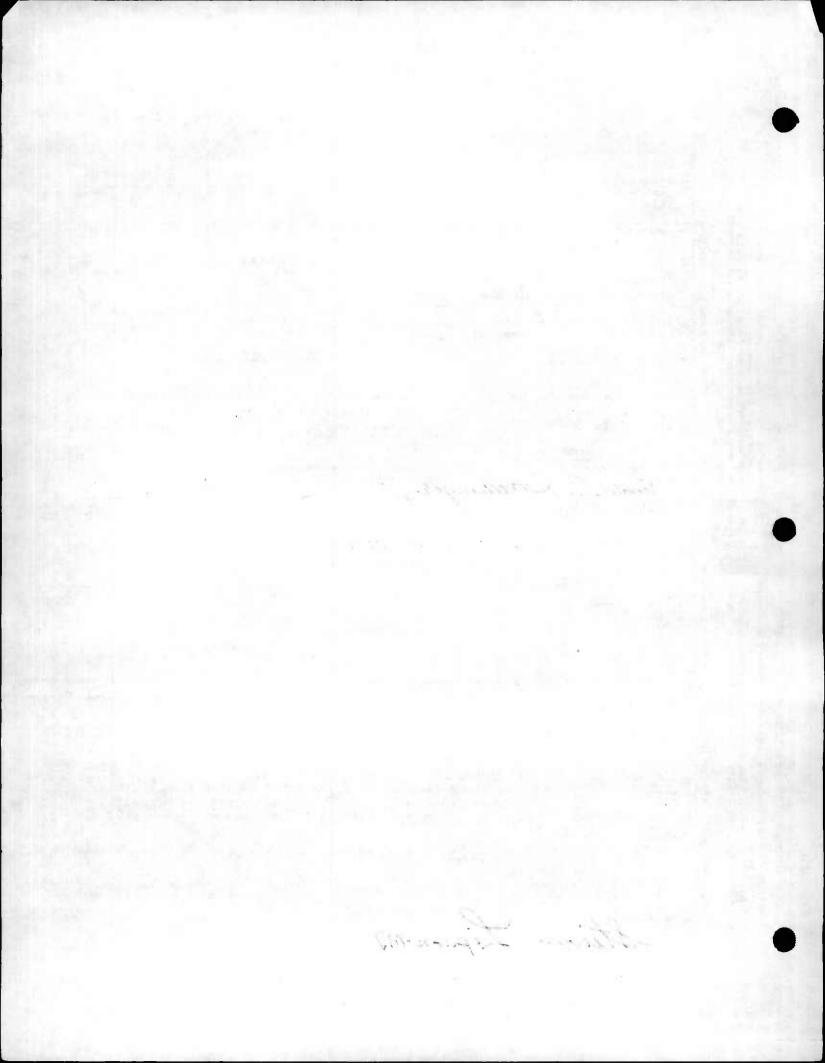
31. Date filed (Month, Dey, Year) MAY 02 2000



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State of Maryland / Department of Health and Mental Hygiene 0 1500

						Cei	rtificate	e of				Reg. No.	1	002	
Phys	sician	1. Decedent's Nama (First, M									2. Date of De Month		Year	3. Tima	
	edical	EVA M. LICHT	CENS!	rein							APRIL	27,2000)	6:25	PM
Exa	miner	4a Facility Name (If not instit	-								ocation of Deatl				
<u> </u>		HEBREW HOME OF							ROCKV			MONTGO	MERY		
Fune Direct		5. Social Security Number 025-01-8438		Sex 1□ M 2□ ₂ F	7. Aga (In yrs. 91	last birthday) Yrs.	If Under 1	Days Days	If Under Hours	24 Hrs. Min.	8. Data of Bir (Month, Da	th ly, Year) R. 7.1908	Con	place (Stata intry) SS	or Foraig
p a		Usual Residence of Deceden 10a. Stata 10b. Cor			100 Ci	tv. Town or Lo	oation					.,_,_,			Oth I limite
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the N	Director	MD . MON'	LGUM	CKI	RUC	KVILLE	101 7:- 1	Codo				10g. Citizen of	MATERIA ()	22	
23th with the Marylan 23a or 28a-f ehow	ral Dir	6121 MONTROSE	ROAI)			10f. Zip ()852	2			U.S.A		antry r	
P de la	by Fune	11. Marital Status 1 Never Married 2 I 3 XWidowed 4 Divor		12. Was Dece Armed Fo 1 Tas If Yas, Giv Year or Do	2 ∄No a		Was Decede If Yes, speci 1 ☐ Yes 2		lispanic Ori an, Mexicar Specify:		ecify Yas or No Rican, etc.)	14. Rec Bla Specif	ck, Whita	ican Indian, , atc. WHITE	
72 hours	Completed	15. Dece (Specify only hi	dent's E	ducetion		16a. Dece	dent's Usual	Occup	oation	t of word	ina	16b. Kind of B	usinass/i	ndustry	
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Hygien th	So	8				HO	MEMAKE	ER					HOME		
# Half	å	17. Father's Name (First, Mid	dla, Last,)					18. Mothe	r's Nam	a (First, Middle	, Maiden Sumen	na)		
should be nd Mental marked c	2	PAUL MAIIOUX							AL	ICE	COT'E				
d 2 should be flie th and Mental Hy 7 Is marked other traumatic event		19a. Informant's Name/Relati	onship (Type, Print)		19b. Mailin	ng Address	(Street	and Numbe	er or Rui	al Route Numb	er, City or Town	Stete, Zi	ip Code)	
and ealth n 27		JACK LICHTENST	CEIN						DR.	POT	DMAC MD				
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is	6	20a. Method of Disposition 1 Burial 2 Cremati 4 Donation 5 Othe			State	Place of Dispo cematary, crer COMFO	natory or off	her pla		15	Data 5/1/00	ALEXANI			
Porte y Inju	SUC.	21. Signature of Funeral Serv		**			. Name and				1				
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/Medic		Immediata Cause (Final disease or condition		CHRON	IC CER	EBRAL I	ISCHEM	1IA						YEAR	S
Examin	er	resulting in death)		a	Dua to (e	or as a consec	uence of):		W 19						
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tificate be ex ng physicien es the burial	Medical	that initiated events resulting in death) Last	1	C	Due to (d	or as a conseq	uance of):						1		
attendir for use	Physician			d									1		
ha dea	0	Part II. Other significant con-	ditions o	ontributing to de	ath but not ras	ulting in the u	nderlying ca	use giv	ren in Pert I		23b. Dld	tobacco use co	ntribute	to the cause	of death
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The lay	Eo										10	Yes 2 No	1	☐Yes 2[□No
ician: The		25. Was casa refarred to med	lical						26. Place	of Deet	h (Check only o				
Physician: this certific	To B	examiner? 1 Yes 2 No		Hospitel: 1 🗆 la	npatient 2	ER/Outpatien	t 3[] DO/	A Oth	ner: 4X Nu	rsing Ho	ma 5□Rasi	dence 6 Oth	er (Spec	ify)	
		27. Manner of Death tX□Natural 5 □ Per	nding astigation	28a. Date of (Month	f Injury h, Dey Year)	28b. Time of Injury		Bc. Injui				how injury occur			
	Certification:	3 Suicide 6 □ Co	uld not b armined	e 28a. Place	of Injury - At h	ome, farm, str fy)	eet, factory,				28f. Location (City or To	Street and Numi wn, Stata)	ber or Rui	ral Route Nu	mber,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier X Certifier (Check only 2 Medi	fying Ph	ysician: To the	best of my kno	owledga, death	occurred e	t the tir	na, data an	d place,	and dua to tha	causa(s) and m	annar as	stated.	(s)
the the	Med	one)		and mann	er stated.										
Withi To th	-	29b. Signature and title of our	mer		P.		_		e number			29d. Date signe			
v	-	su	m	- 1	upa	only	DO DO	0588	35			APRIL 2	28,20	000	
		30. Name and address of pers	son who	completed cause	a of death (Iter	n 23a) (Type,	Print)								
		STEVEN LIP		6121 MC	NTROSE	ROAD	ROCKVI	LLL	MD.	208	52				
	State	31. Data filed (Month, Day, Ye		32. R	gistrar's Signa	ature 4	Spo								
Regi	strar	MAY U	2 20	JUU A	The same	N.	1000	w							



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State of Maryland / Department of Health and Mental Hygiene 15893

				Ce	ertificate o	f Death			Reg. No.	65	11.00
S hootsis	1. Decedent'a Name (First,	viiddla, Last)						2. Dete of De		Year	3. Time of Death
Physicia /Medica	0036011	Armond	o List	trani				April	29, 2000		3:30 AM
Examine	A- C- 100 - Al Df 1			02		4b. City, To Laure		cation of Deat		of Death Aru	ndel
Funeral Director	5. Social Security Number 577-03-6861	6. Sex 1√3√M 2□		s. last birthday Yrs.	Months Dev			8. Date of Bir (Month, Da July 2	th ay, Year) 4, 1914	9. Birthp Coun Per	lace (Stata or Foraign try) nnsylvania
	Usual Residence of Decede										
death with the Maryland ms 23a or 28a-f show r must be notified at	Maryland Ann	unty e Arundel		City, Town or L ure1	ocation.					1	0d. Inside City Limits 1☐ Yes 2☐ No
3a or 28 at be no	Maryland Ann 10e. Street and Number 3529 Piney W	oods Place	е #Н302		10f. Zip Code	724			10g. Citizen of W United S		-
h 28	11. Merital Stetus 1 Never Married 2	Married Arme	Decedent Ever in od Forces? Yes 2 No	U,S. 13.	Was Decedent of If Yes, specify C		gin? (Spe n, Puerto F	city Yas or No Rican, etc.)	14. Race Black Specify:	- Americ k, White,	etc.
etural',	3 Widowed 4 Dive	rced Year	or Dates:							WII.	ite
of 2 should be filed within 72 hours all th and Mercial Hygiene. If is marked other than "natural", or traumatic event, the Medical Exam	15. Dec (Specify only I	edent's Education ighast grade compla 12) Colle	ded) ge (1-4or 5+)	(Give	adent's Usual Occ e kind of work doi DO NOT use rati	na during mosi red)			16b. Kind of Bu		
Hygier the mut. Its	5 12			Busin	ess Owne	-			Dry C1		ng
the first	17. Father's Neme (First, Mi					18. Mothe	er's Name	(First, Middle	, Maidan Sumem	θ)	
should be nd Mental marked c	2 Romeo List						know			201 2	
12 sh n and le m	19a. Informant's Name/Rela								er, City or Town,		
	Joanne Listra	ni-Powell,			29 Piney of Name of	Woods	Plac	-	2 Laurel	-	
	20a. Method of Disposition 1 ☑ Burlel 2 ☐ Creme 4 ☐ Donation 5 ☐ Oth		rom State	cematery, cre	ametory or other panents of the control of the cont		0	Date 4/30/0	20c. Location -		
permit. Pages 1 a Department of Hea Important: if item any injury or othe stice.	21. Signature of Funeral S	vice Licensee	6	-11	22. Name end Add		Ian		neral Horgton, DC		1.2
	23a Part Enter William	e or complications t								2001	Approximate
	23a Part1. Enter the disease shock, or beart feilure.	List only one cause	on each line.	etti. Do not et	iter the mode of c	ying, such as	Cardiac o	r respiratory a	rrest,	1	Interval Between Onset and Death
Physician /Medical	Immediate Cause (Finel	0	AAA / IA	TA1.1	CAD CINA	414.					
Examiner	disease or condition resulting In death)	a	Boy CHO6	ENIC	Chicipa	МЛ				1	12+ MONUTHS
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al-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	-	Due to	(or as a conse	equence of):						
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certificate be executed ding physician and se as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Due to	(or es e conse	quence of):						
death or	Part II. Other eignificant co	nditione contributina	to death but not re	esuiting In the	underfying cause	given in Part f		23b. Did	tobacco use con	ntributa to	the cause of death
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Physician: The law requires that the death of this certificate has been signed by the attentral director, page 2 should be detached for until	Part II. Other eignificant co					(E			en autopsy	av	ere autopsy findings allable prior to
The law re ate has be page 2 sh		E HOT/C	, <u>/(101/) </u>	SCOUNI	e ly is ert) L			Yes 257No	of	mpletion of cause death?
ysician: The list certificate he director, page		dical				OC Disease	ad Daath				7143 20140
Physician: this certific ral director,	n examiner?	Hospital	4 Diametria	DED/Out-wis		Other:		(Chack only		(0	
Ing Phys		28a. I	1 ☐ Inpatient 2 Dete of Injury (Month, Day Year)	28b. Time Injury	of 28c. Ir	4 LI NU	2		idenca 6 Other		y)
l or Attending after death. Director; Afte d in by the fune	2 Accident 3 Suicide 6 C 4 Homicide	vestigetion ould not be stermined 28e. F	Place of Injury - At puilding, etc. (Spec	home, ferm, s				28f. Location City or To	(Straat and Numb wn, Stata)	er or Aure	al Routa Number,
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	27. Manner of Death 1 CNatural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	tifying Physician: To	o the best of my kr	nowledge, dee	th occurred et the	time, dete en	nd plece, e	end due to the	cause(s) end ma	nner es e	tated.
the H the F the F		and	nanner stated.	- State of the							
OF WELL	29b. Signature end title of co	hill V				nse number	_		29d. Date signed	(Month,	Day, Year)
4	1	yar -	74			DZ403	35		5/1/	00	
	30. Name and eddress of	rson who completed	cause of death (Ite	em 23a) (Type							
	Eugenio Macl	ado 321 P	rince Ge	orge S	t. Laure	1, Mar	yland	20707			
Stat	31. Date filed (Month, Day,	(ear)	32. Registrar's Sign				14-2				
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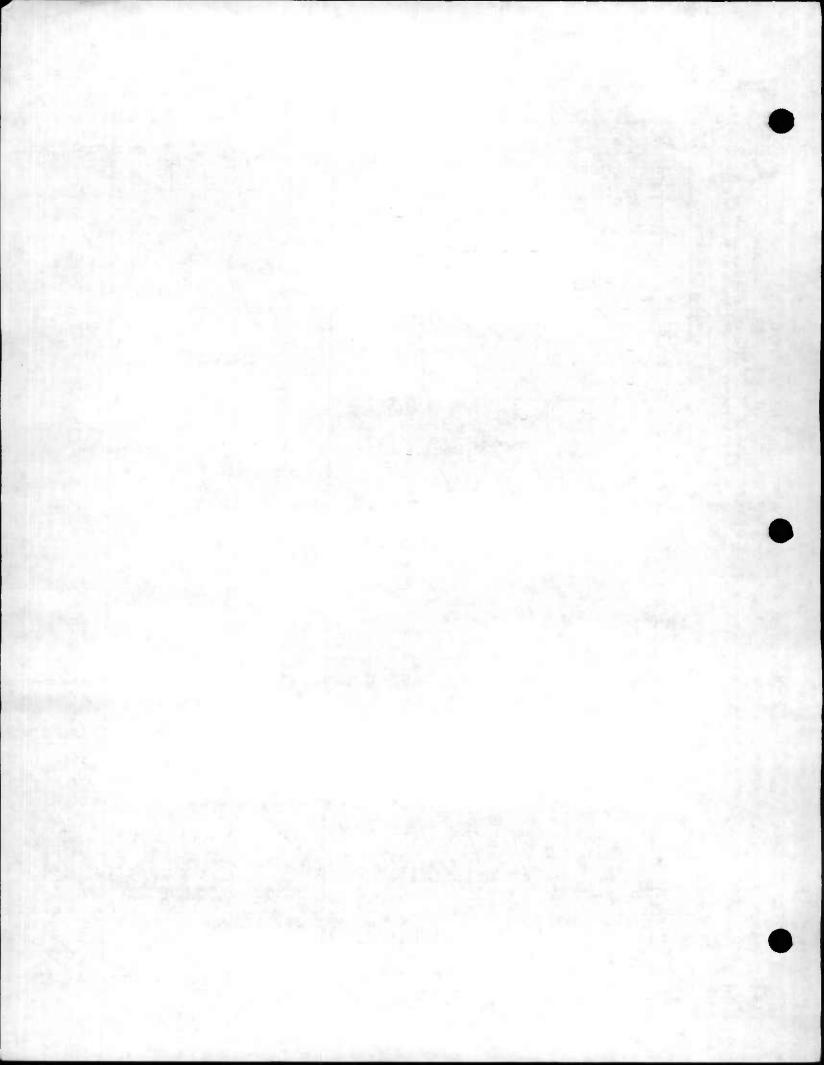
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00-2386-510 Anton D. Lomax JVW

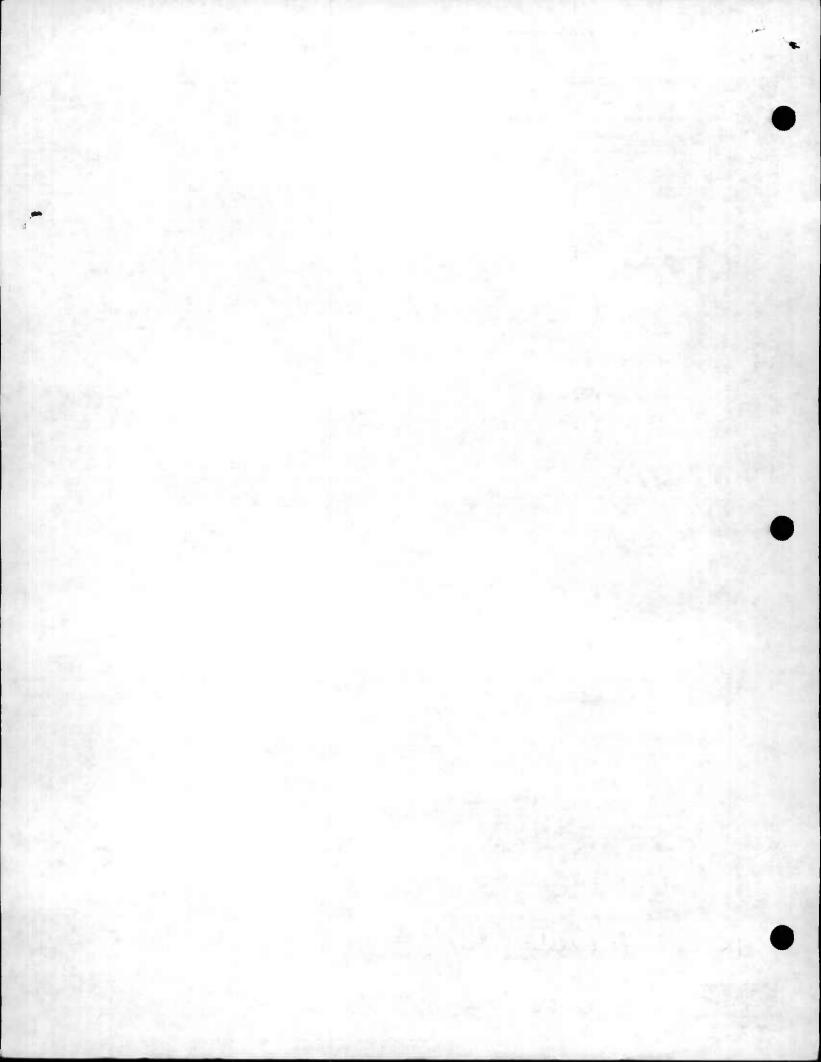
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	D. Dallax		State of Mar		epartment of Certificate o			giene	15894
0	Physician /Medical	Decedent's Name (First, Middle ANTC		AX, JR			2. Dete of De Month April	Dey Ye	3. Time of Death 03:47 A.M.
-	Examiner	4a Facility Neme (If not institution 1002 North Calv 5. Social Security Number	vert Street 2	nd Floor		4b. City, Town, or Baltimore	9		
	Funeral Director	213-90-4105 Usuel Residence of Decedent	AFTM OF F	24 Yr	Months Day		(Month, De	, 1976	Birthplece (Stete or Foreign Country) Maryland
	daryland f ahow ed at	10a. Stete 10b. County	1	Oc. City, Town o	r Location				10d. Inside City Limits ★SYes 2 □ No
	3a or 28a-fall to notified	10e. Street and Number 1002 N. Calv	vert Street		101. Zip Code	21202		10g. Citizen of Whell	
020	72 hours after death with the Maryland naturel, or florms 23s or 28s-4 show seel Examiner must be notified at seed by Funeral Director	11. Meritel Stetus 1 ঐNever Married 2 ☐ Merri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Event Armed Forces? 1 Yes 2 M No If Yes, Give Year or Detes:	er in U,S.	13. Wes Decedent of If Yes, specify Control of Yes 200 N	f Hispenic Origin? (Suben, Mexican, Puerlo o Specify:	Specify Yes or No to Rican, etc.)		American Indien, Vhite, etc. Black
Maryland 21215-0020	within than than man	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th		(0)	ecedent's Usual Occ Give kind of work dor le. DO NOT use reli Security	ne during most of wo red)	rking	16b. Kind of Busine	ess/Industry
yland	should be filed and Mental Hygis marked other umatic event, I	17. Fether's Neme (First, Middle, I					me (First, Middle, eila Da	Maiden Sumeme)	
	and in m	19e. Informant's Name/Reletionsl Sheila Davis						er, City or Town, Ster	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr angles.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (St	3 Removal from State	cemetery,	isposition (Name of crematory or other p		Dete 5/6/00	20c. Location - City	
Balt	Departi Departi Importa any inju	21. Signature of Funerel Service I	L'Anor	Den		ress of Facility N FUNERA LLE, MD	AL HOME 20850	•	
	Physician /Medical Examiner Examiner Examiner	23a. Perf 1. Enter the see, or shock, or heart fame. List Immediate Cause (Final disease or condition resulting in death)	· Gc	LNS 0	tot	A		OF He	Approximate Intervel Between Onset and Death
Box 68760,	ficate be physicial is the bur edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	С	e to (or as e cor					
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Vital R	iclan: The li certificate ha rector, page	25. Was case referred to medical examiner?					eth (Check only o	one)	1⊞Ves 2□ No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Year **Physician** May 2, Sara Elizabeth MacIntosh 2000 7:50PM /Medical 4b. City. Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** 3817 Williams Lane Chevy Chase Montgomery | Girevy | Girevi | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Dey. Year) | 9. Birthplece (Statement of Month) | 9. Birthplece (Statement of Month, Dey. Year) | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1918 | 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foraign Country) **Funeral** 1 ☐ M 2 🕅 F Yrs. 231-62-6456 81 Director Usuel Residence of Decedant 10c. City, Town or Location 10a. Stete 10b. County 10d. Insida City Limits Items 23s or 28a-f show 1 ☐ Yes 2 No Hygiono. sther than "natural", or Heme 23e or 28e-1 er ent. the Medical Examiner must be notified Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3817 Williams Lane 20815 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Detes: 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry ould be filed within Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) Be Ella Moor Paul Augustus Stevens Pages 1 and 2 should 2 Department of Health and I important: If item 27 is ma any injury or other traums 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Patricia Darling Dean/Daughter 3817 Williams Lane, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Placa of Disposition (Name of cametary, crematory or other place) 20c. Location - City or Town, Stete May 4, 1 ☐ Burlal 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 21. Signetura of Funerel Service Licensee 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Chaplin Am F M00092 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Pert1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrest, shock, or haart taiture. List only one cause on each lina. Approximata Intervei Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Inanition Months disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Type 2 Diabetes Mellitus Years sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760. physician Physician/Medicai the Due to (or as a consequence of) 88 USB P.O. Part II. Other stanificant conditions contributing to death but not resulting in the undertying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed b of Vital Records, p 24b. Wara autopsy tindings available prior to complation of cause of death? should Completed 24a. Wes en eutopsy performed? page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, pi Be 25. Was case reterred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital c within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steled. Medicai 29a Certifier (Check only one)

State Registrar 29b. Signature and titla of certifie

31. Date tiled (Month, Dey, Year) 32. Registrer's Signature MAY 05 2000

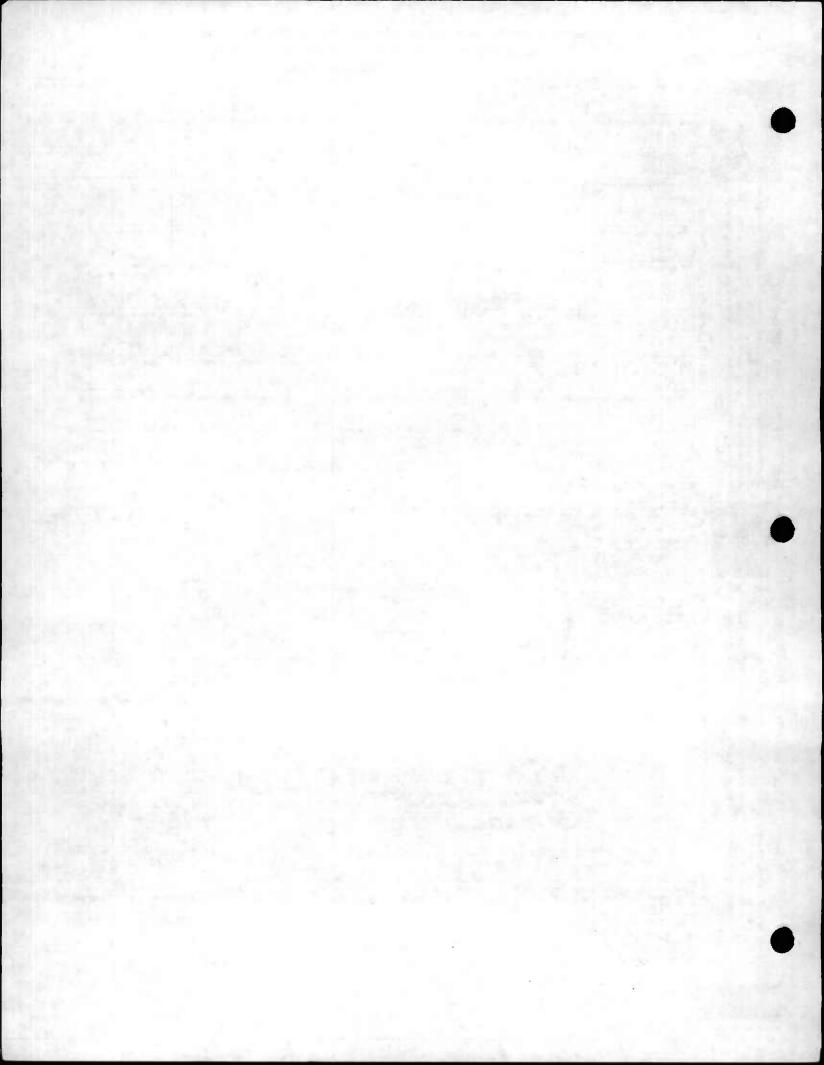
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

5530 Wisconsin Avenue, #930, Bethesda, Maryland 20815 Lila T. McConnell, M.D. Inne Kal renewa

29c. License number D39456

29d. Date signed (Month, Day, Year)

May 4, 2000



00-2490-510

MCMAHON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			S	State	of M	aryland	Department of Health and New Certificate of Death	Jental Hygie
MEND	ITEMS:	#23	PART	I.	27.	28A-F	PER MEO 6/84 6-13-00	WK.
		,,		-,	,		Centificate of Death	Reg

7. Age (In vrs. last birthday)

	ı
Physician	ı
/Medical	ļ
Examiner	l

Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month Day Vasi 5:29P.M. Samuel Waters McMahon MAY 03, 2000 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death

If Under 1 Yaar

Funeral Director

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Funeral

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Completed

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To

Certification:

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filed within 72 hours after

Pages 1 and 2 should be filed within nant of Heelth end Mental Hygiene. ant: If Item 27 Is marked other than ury or gither traumatic event, the M

Saltimore, Maryland 21215-0020

6. Sex 1 M 2 F 8. Date of Birth (Month, Day, Year, Days Months Hours 19 Nov 23, 1980 215-06-9646 10b. County

10a. Stete

5. Social Security Number

SHOCK TRAUMA CENTER

10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Rockville

10f. Zip Code

10e. Street and Number

11 Marital Status

20853 4124 Great Oak Road 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc. Specify: White

DC

Birthplece (State or Foraign Country)

1 Never Married 2 Married 3 Widowed 4 Divorced

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Yes 2 No

16b. Kind of Business/Industry

10g. Citizen of What Country?

USA

N/A

15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student

17. Father's Name (First, Middia, Last)

18. Mother's Name (First, Middle, Maiden Surnama)

Kevin McMahon

Dorea Saxon 19a. Informant's Name/Relationship (Type, Print)

College (1-4or 5+)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Kevin McMahon / Father 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

4124 Great Oak Road, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date

Specify:

If Undar 24 Hrs.

Gate of Heaven Cemetery

5/8/00 Silver Spring, MD

20853

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Nama end Address of Facility Francis J. Collins Funeral Home, Inc.

500 University Blvd, W. Silver Spring, amas MD 20901 23a. Part1. Enter the disease, or complications that clused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Physician /Medical Examiner

physician and s the burial-trans

957

page 2

Aftar this

To the Hospital or Attending Pt within 24 hours after deeth.
To the Funeral Director: After the completely filled in by the funera

Box 68760. the death certificate be

P.0.

Records,

of Vital

Division

permit. Pages Depertment of I Important: If Its any Injury or g

Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

MULTIPLE INJURIES

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performad?

24b. Were autopsy findings available prior to completion of cause of death?

2 No

	, ,	
Check	only one)	

1X Yes 2□ No

25. Was case referred to medical 1(XYes 2□ No 27. Manner of Death

28e. Dete of Injury (Month, Day Year) 5 Panding investigation 5-3-00 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA 28b. Time of Injury 4:30

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

GARAGE

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

26. Place of Death /

28d. Describe how injury occurred SUBJECT JUMPED FROM ROOF OF GARAGE

RD.

281. Location (Street and Number of Bural Route Number City or Town, State) 825 DULANEY VALLEY

TOWSON, MD

29e. Certifier (Check only one)

1 Netural

2 Accident

3X Suicide

4 Homicide

1 Certifying Phyelclen: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

29b. Signeture and title of certified

29c. License number O.C.M.E.

MAY 4,2000

30. Name end address of person

who completed cause of deeth (Item 23a) (Type, Print)

MID

111 Penn Street, Baltimore, Maryland 21201

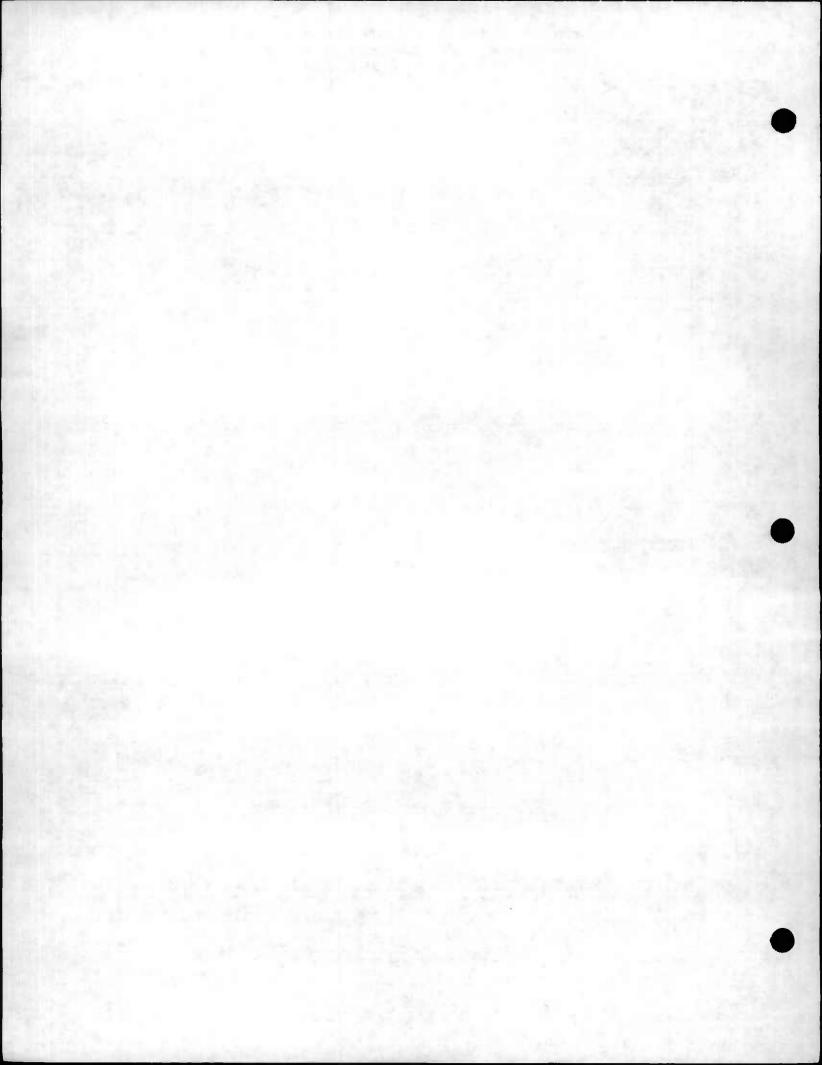
State Registrar 31. Date filed (Month, Day, Year)

JACK M.

32. Registrar's Signature

Docks

P

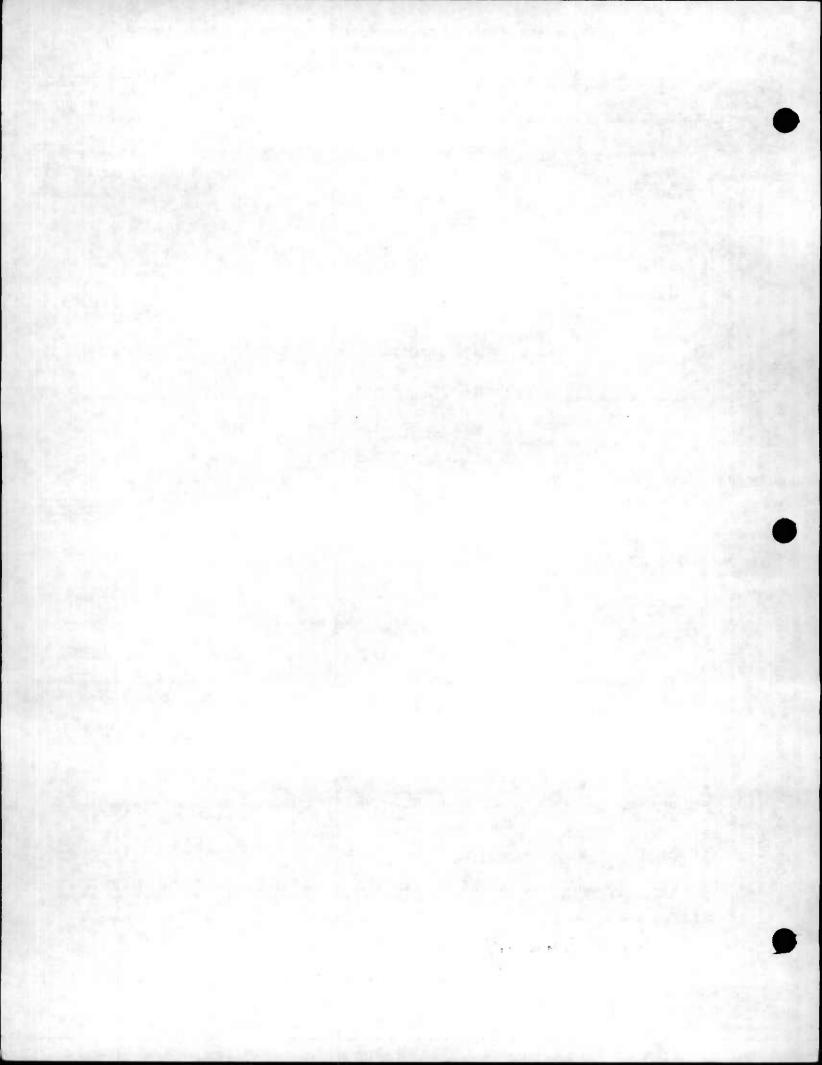


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ate of Maryland / Department of Health and Menta	I Hygiene 🗎 🗎	15898	
Certificate of Death	One No	, 00	

					Cerunc	ate of t	Deam		Reg. No.			
Physician /Medical	Decedent's Name (F		Fructuoso	Morales				2. Dete of De Month April	Dey 27, 20		3. Time of De 11:10	
xaminer	4a Fecility Neme (If no.	t institution, give	street and number)			4	4b. City, Town, o	r Location of Deet	h 4c. County	of Deeth		
4			orgia Ave				Silver	Spring		ntgom		
ral	5. Social Security Numb		ex 7. Ag Mom 2□ F	e (In yrs. last bir	Mont	der 1 Yeer	If Under 24 H Hours M		th by, Year)	9. Birthp Coun	olece (Stete or F	oreign
r	581-68-877	9	Z W Z D F	82	Yrs.			October			rto Rico	
	Usuel Residence of De 10a. Stete 10	b. County		10c. City, Tow	n or Location					1	IOd. Inside City I	Limite
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DIRECTOR	Maryland	Montg	omery				ilver S	pring				XX
9	10e. Street and Numbe	r			10f.	Zip Code			10g. Citizen of \	Whet Cour	ntry?	
by Funeral		11 Geor	gia Avenu				20910			ed St		
Urie	11. Meritel Stetus		12. Wes Decedent Armed Forces?		13. Was De	ecedent of H specify Cube	fispenic Origin? en, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Rad Bled	ce - Americ ck, White,	etc.	
y	1 Never Merried		1 X Yes 2 ☐ I If Yes, Give	No	1 🏹 Yes	s 2 No	Specify:		Specif	y:		
	3 Widowed 4			1941-1971			Puerto	Rican		Wł	hite	
		Decedent's Ed only highest gre		16e.	Give kind of	work done	during most of v	vorking	16b. Kind of B	usiness/Inc	dustry	
Completed	Elementery/Seconda	ry (0-12)	College (1-4or !		life. DO NO		•		4			
3	12 Eather's Name (Fire	A Adiabata I a ast		N	on Com	missi	oned Of		United		s Air b	force
0	17. Fether's Neme (Firs	st, Middle, Last)					16. Mothers N	leme (First, Middle	, Maiden Sumen	16)		4.77
0			tuoso Cru						lia Mora			
	19e. Informent's Neme	/Relationship (7	Type, Print)	19b	. Meiling Addr	ess (Street	end Number or	Rural Route Numb	er, City or Town,	Stete, Zip	Code)	
	Yvette Kro		ghter				Avenue	Severna I				5
	20e. Method of Disposit		Removel from Stete	20b. Plece of cemeter	Disposition (y, cremetory	Neme of or other place	ce)	Dete	20c. Location -	· City or To	own, Stete	
	4 Donetion 5			Arlinot	on Nati	onal C	emeterv	May 10,2000	Arling	ton.	Virgini	2
	21. Signeture of Funere	ol Service Licen	see /	111111111111111111111111111111111111111	22 Name	and Addre	ss of Fecility	Funeral	Home /	20113	. Y AL BALLA	- 54
			Y/L		Bethe	sda-C	hevy Ch	y Funeral ase, Inc. d 20814-	7557 W	Iscor	nsin Ave	enue
+	23a, Pert1, Enter the	iseese, or come	lications that caused	MUU335	Bethe	sda,	Marylan	d 20814-	rrest		Approximete	
	23a. Pert1. Enter the di shock, or heart fa	ilure. List only	one cause on each li	ne.	101 011101 1110 1			ac or roop or or,			Interval Between	
	Immediate Ceuse (Fine	al										
	disease or condition resulting in deeth)		e. <u>No</u>	n Small	Cell :	Lung (Cancer				6 Month	S
-				Due to (or es e	consequence	of):				1		- 19
			b							i		
edical Examiner	Sequentially list conditi if any, leeding to imme- cause. Enter Underlyin	ons, diete		Due to (or es e	consequenca	of):				i		
2	Cause. Enter Underlyin Ceuse (Disease or Injuration that initiated events	ng ry	c		46	942				1		
	resulting In death) Lest			Due to (or es e	consequence	of):						
υ/Me			d									
lan										- 1		
Physicia	Pert II. Other significan	nt conditions co	ontributing to deeth b	ut not resulting in	the underlying	ng cause giv	en in Pert I.	23b. Dld	tobacco use co	ntributa to	o the causa of c	death?
	Hyperi	tension						1 🔯	Yes 2 No	3 Prof	bably 4 □ Un	known
2	пурет	cension	_							1		
Completed by									en eutopsy ormed?	ave	ere eutopsy find eilable prior to	
pie								-		of	mpletion of ceu death?	se
0								10	Yes 2 No	1[□Yes 2□No	0
2	25. Wes case referred	to medical					26 Place of E	eath (Check only	one)	1		
	examiner? 1 ☐ Yes 2 ☒ No		Hospitel: 1 ☐ Inpatie	ent 2 ER/Ou	tnatient 3	DOA Oth	OF'	Home 5 N Res		ner (Snecif	(v)	
1: To	27. Menner of Deeth		28e. Dete of Inju	ry 28b. 1	Time of	28c. Injur		1	how injury occur		37	
tlor	1 Naturel 5	Pending investigation	(Month, De	y Year)	nj <i>u</i> ry M		rk? Yes 2∐No					
fica		☐ Could not be		ury - At home, fe	rm street fec	1		28f. Location (Street end Numb	ber or Rure	al Route Numbe	or.
Certification:	4 Homicide	determined	building, et	c. (Specify)	iii, 30000, 100	nory, ornice			wn, Stete)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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Med		CAUCAGE C	end menner st	eted.		20a Hisana			and Data sing	d (I do not	Day Vess)	
	29b. Signeture and title	or certifier	/			29c. Licens	10(1109f		29d. Date signe	a (wonth,	Day, rear)	
	Kaya	X B	ennes'i			0	65084-L		April	28,	2000	
	30. Neme and eddress	of person who	completed cause of d	leeth (Item 23a)	(Type, Print)							
	Rajat Bann	erji. M	.D. Walter	Reed A	rmv Me	dica1	Center	Washingt	on, D.C.	. 203	07	
tate	31. Dete filed (Month, D	Day, Year)	32. Begistr	er's Signeture								
istrar	MAY	0 2 200	10 Done	un 1	9 1	much	/					

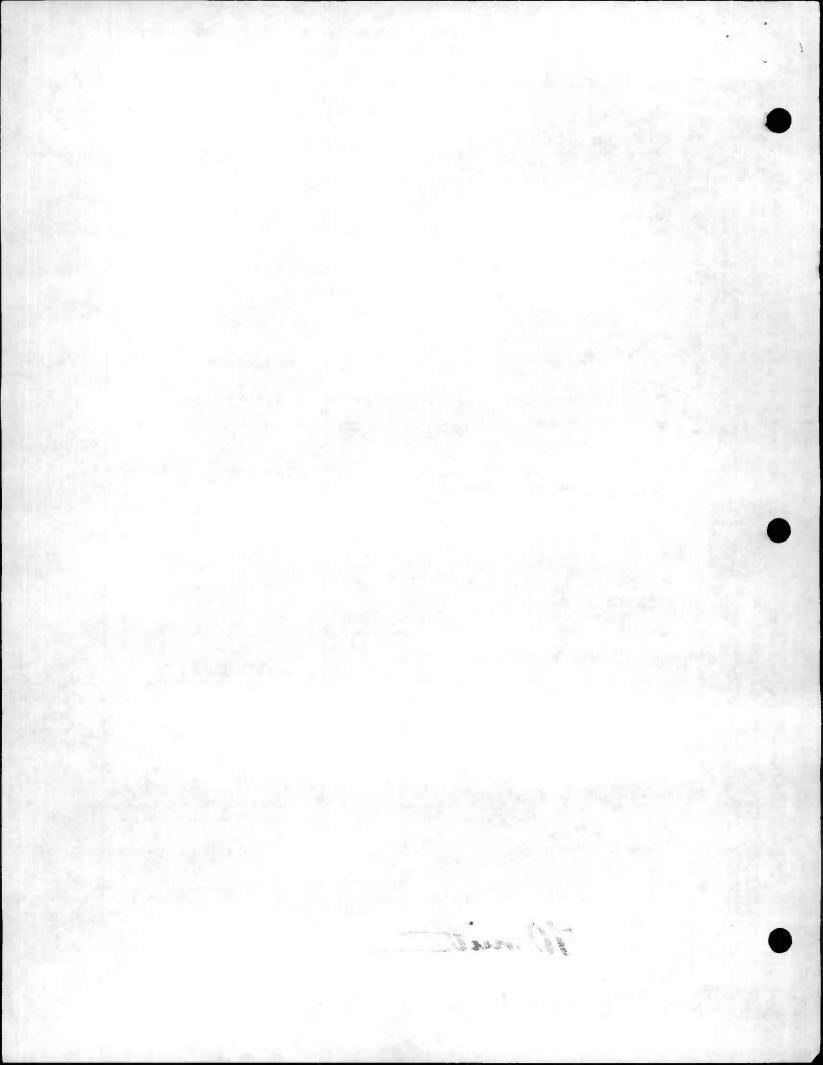
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene DONNIE E MOULDEN JR. AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DONNIE E. MOULDEN II 9, 2000 MAY 0544 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 109 WEST JEFFREY STREET BALTIMORE NONE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** IXOMM 2□ F Yrs. Director 219-55-7438 1999 MARYLAND SEPT. 28 Usual Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2□No Director MARYLAND BALTIMORE NONE 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA JEFFREY STREET 21225 109 WEST Funeral 14. Raca - American Indien, Bleck, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status hours effer 1 Yes 2 No If Yes, Give Yeer or Dates: Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry filed within 72 Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) NONE NONE 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be nent of Health end Mental DENISE A. DOVE la merked DONNIE E. MOULDEN 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 109 WEST JEFFREY ST. BALTIMORE, MD. 21225 Health e DENISE A. MOULDEN (MOTHER) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 20a Method of Disposition Department of H Important: If ite any Injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HILL CREST CEMÉTERY 5/13/00 ANNAFOLIS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee MOD483 22. Name and Address of Fecility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final BLUNT FORCE INJURIES OF HEAD diseese or condition resulting in death) Examiner Due to (or es e consequenca ol): Examiner physicien end the burial-trensit the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as e consequence of) 9SD ö 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yee 2 No 3 Probably 4 Unknown signed I Records, þ 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 No 1 Yes 2□ No certificate of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2□ No To this 28e. Dete of Injury
FOUND:
5-9-00 28b. Time of A 28d. Describe how Injury occurred To the Hospital or Attanding PI within 24 hours effer death.
To the Funeral Director: After it completely filled in by the funere Certification: 27. Manner of Death 28c. Injury et Work? After Division 1 Netural 5 Pending investigation EQUNIS 1 ☐ Yes X No CHILD ABUSE 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Soach) AT HOME 281. Location (Street end Nymber or Rural Route Number ST. 4 Homicide BALTO. CITY, MD. Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dete end placa, end due to the ceuse(s) and manner as stated.

**Pledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E 9, 2000 MAY ass of person who completed cause of death (Item 23a) (Type, Print) es 111 Penn Street, Baltimore, Maryland 21201 Truer 32 Registrer's Signature 31. Date filed (Month Dev. Year) State MAY 1 2 2000

Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 0650N 8:30 Am ESTELLA 2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Laurel Prince George's -aure/ Hours Min. 8. Date of Birth (Month, Dey, Year) Sept. 8, 9. Birthplece (State or Foreign Country) Virginia If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Deys 1□M 2XXF Months 227-12-4868 85 Yrs. 1914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2 □ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9305 Biltmore Drive 20901 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedant Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2□ No Spacify: Specify: S Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Waitress Food Service 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Paul Nicholson Rosa Sisk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Donald Olson - Son 711 Malibu Drive Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or othar place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removel from State Etlan Cemetery 5/5/00 Etlan, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funaral Sarvice Licansa 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA The the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximata Interval Between Onset end Death Unerry Treat Arfeilein Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as e consequence of): Dua to (or as a consequence of) 23b. Did tobecco use contribute to the ceuse of death? Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en eutopsy completion of ceuse of death? 1 Yas 1 Tyes 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 Appatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 1 Naturel 2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

edical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Physician

/Medical

10a State

MD

Director

Funeral

þ

Completed

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show mortal principles of other traumatic event, the Medical Example must be negligible.

Baltimore, Maryland 21215-0020

death with the Maryland

attending physician and for use as the burial-transit signed by the al been si Hes

eral Director: After this certificate filled in by the funeral director, pag death. after

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicisn: within 24 hours a To the Funeral Completely filled

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denerra

2000

5 Pending investigation

6 ☐ Could not be

MAY 03

Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

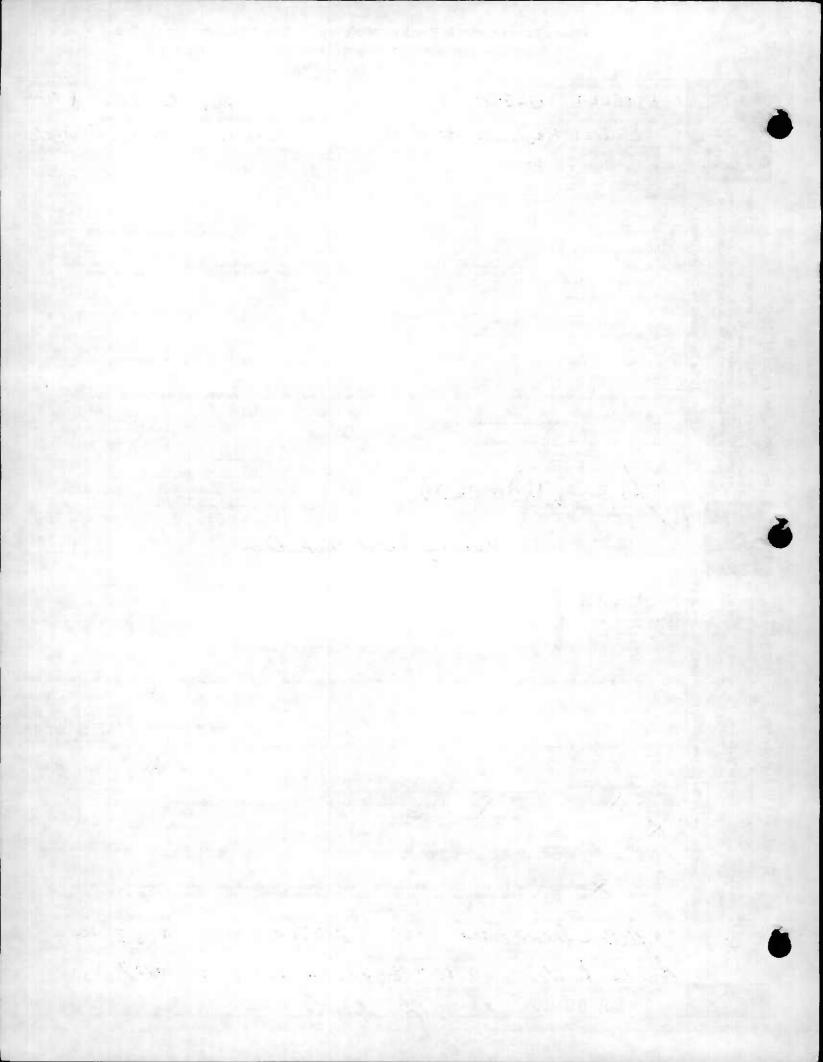
28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

8317 Cherry Lane, Laurel, W1/20707 M.D. Invoew 31. Date filed (Month, Day, Year) 32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

State Registrar



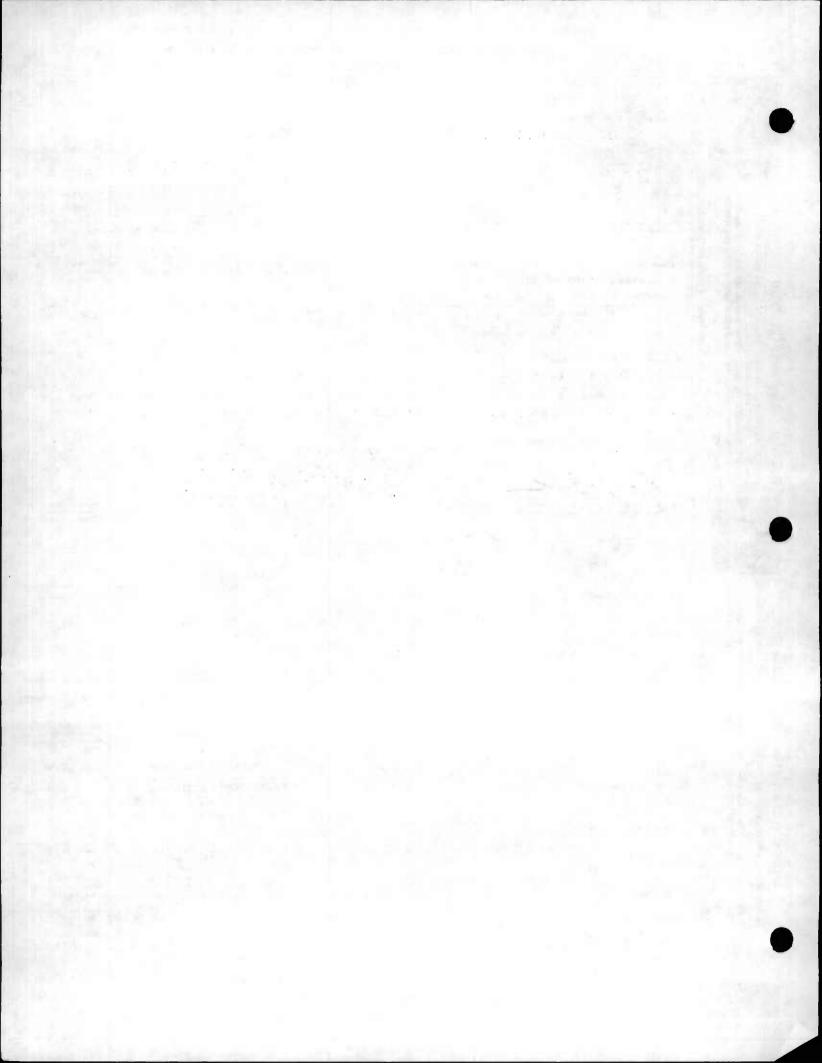
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State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death 3. Tima of Death April 27, 2000 **Physician** Patricia Ann Perryman 12:00 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Deeth Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year)
Dec. 1, 1944 9. Birthplaca (Stata or Foreign Country) Maryland 6. Sax **Funeral** Months Days 1 □ M 2 🖾 F 55 219-42-3859 Yrs. Director Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Rockville or 28a-f Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 195 Leland Street 20850 United States Ногие 23а Funeral 14. Raca - American Indien, Black, Whita, atc. 11. Marital Status 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) ntal Hygiene. ed other then "netural", or then event, the Medical Examiner. pemilt. Pages 1 and 2 should be tiled within 72 hours ahar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "matural", or its any Injury or other traumatic event, the Medical Examina 1 Nevar Marriad 2 Married 1 ☐ Yas 2 🛣 No If Yas, Giva Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ğ 3 Widowed 4 Divorced Yaar or Datas: White Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Landscape Designer Landscaping 4 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be John Edward Murphy Gwendolyn Floyd 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 195 Leland Street, Rockville, Maryland 20850 Larry D. Perryman/Husband 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata May 1 Gate of Heaven Cemetery 2000 4 ☐ Donation 5 ☐ Othar (Specify) Silver Spring, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee 0 20 M00198 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical tmmediata Causa (Finel Massive Subarachnoid bleed disaase or condition resulting in daath) Examiner Due to (or as e consequenca of) Examiner Cerebral Aneurysm The law requires that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, leeding to immadiate causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as e consequenca of): Records, P.O. Box 68760. Brain Death Physician/Medical Due to (or es e consequence of): USB AS lor signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? has page 2 1 ☐ Yas 2 🖾 No 1 ☐ Yas 2 ☐ No certificate of Vital or Attending Physician: 25. Was casa refarred to medical axaminer? Be 26. Placa of Death (Check only ona) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2⊠ No this funeral 27. Mannar of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending invastigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 6 4 Homicida filled in To the Hospital o within 24 hours af To the Funeral Di completely filled i 1 Cartifying Physician: To the best of my knowledga, daeth occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

| Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, daath occurred et the time, date end place, end due to the causa(s) and mannar stated. 29a. Cartifiar (Check only one) 29b. Signature and fitting continue 29c. License number 29d. Date signed (Month, Day, Year) D0029224 April 27, 2000 10 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) Saied Jamshidi, 9801 Georgia Avenue, Silver Spring, Maryland 20902 M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAY 02 2000 Registrar Elneva Sparke

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

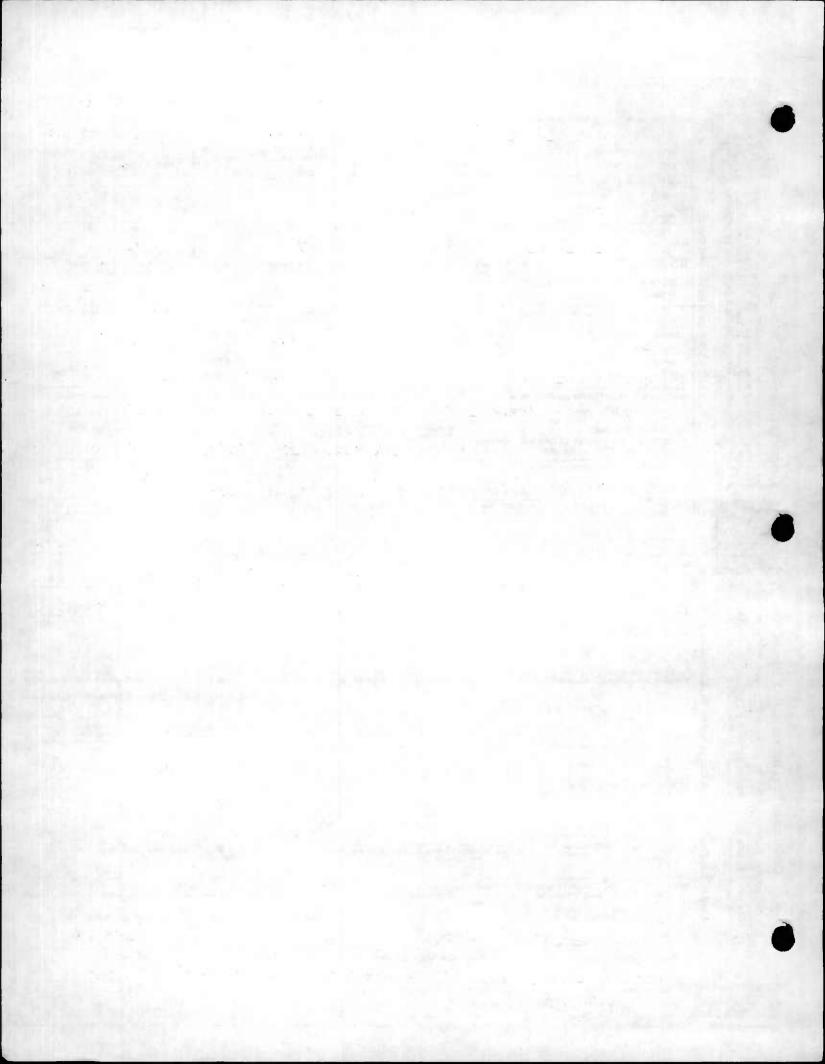
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey 27, 2000 Month **Physician** APRIL 1:30 PM THELMA POWELL /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGES 814 West Street Laurel If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Dey. Year)
Apr. 17, 1910

8. Birthplece (State of Country)

Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2 197 F Yes 217-80-7100 90 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show important or other traumatic avent, the Mexical Examinations to notified at page. 11 Yes 2 No Director MD Pr. Geo. Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 814 West Street 20707 U.S.A. Funeral 14. Race - American Indien, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baitimore, Marviand 21215-0020 1 Yes MNo Specify: Specify: Black P 312 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife Home 6th 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Watkins Idell Corbert 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 814 West Street, Laurel, MD 20707 Barbara Hughes (Daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition Buriat 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Nat'l Mem. Park 5/3/00 Laurel, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Fecility SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each tine. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disaese or condition resulting in deeth) Examiner Physician/Medical Examiner 5 eus e UNGEL physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): per Records, P.O. Box 68760, tens lon Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy tindings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yas 2 No certificate Division of Vitai al or Attanding Physician: T s after death. Il Diractor: After this certificat ed in by the funaral director, p Be 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1, Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as steted.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted. Medical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Yaar) 29b. Signatura and titla of certifian 29c. License number April 28/2000 M (0 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 14201 Laurel Park Dr., Laurel, MD 20707 Armstrong, Paul M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signeture State MAY 01 2000

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death **Physician** MAY 2 2000 CLIFTON L. PRATHER 6:30 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Layhill Center Silver Spring MONTGOMERY If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours XOM 2□ F 216-40-9800 Yrs. Director 56 June 1,1943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or frems 23s or 28s-f show the Medical Examiner must be notified at 15 Yes 2 No Director Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17736 Larchmont Terrace 20877 U.S.A. Funeral 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Wes Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours effer o Department of Heelith and Mental Hyglene. Important: if item 27 is marked other than "naturel", or item eny injury or other traumetic event, trail Medical Emerican and once. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2€ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) llth Custodian Montg. Co. Schools 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wendall Duvall Mary Ellen Prather 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 9747 Lake Shore Dr., Gaithersburg, MD Hazel Prather (Daughter) 20885 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Emory Grove Cem. 5/6/00 4 Donetion 5 Other (Specify) Gaithersburg, MD 21. Signaldre of Funeral Service Licens 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. and ROCKVILLE, MD 20850 23a. Per 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart to the List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed physicien and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760 that initiated events resulting In deeth) Last Due to (or es a consequence of) P.O. I been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? After Natural 2 Accident 5 Pending Investigation deeth. 1 ☐ Yes 2 ☐ No within 24 hours after deeth To the Funeral Director: , completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ro the Hospital or within 24 hour To the Fir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

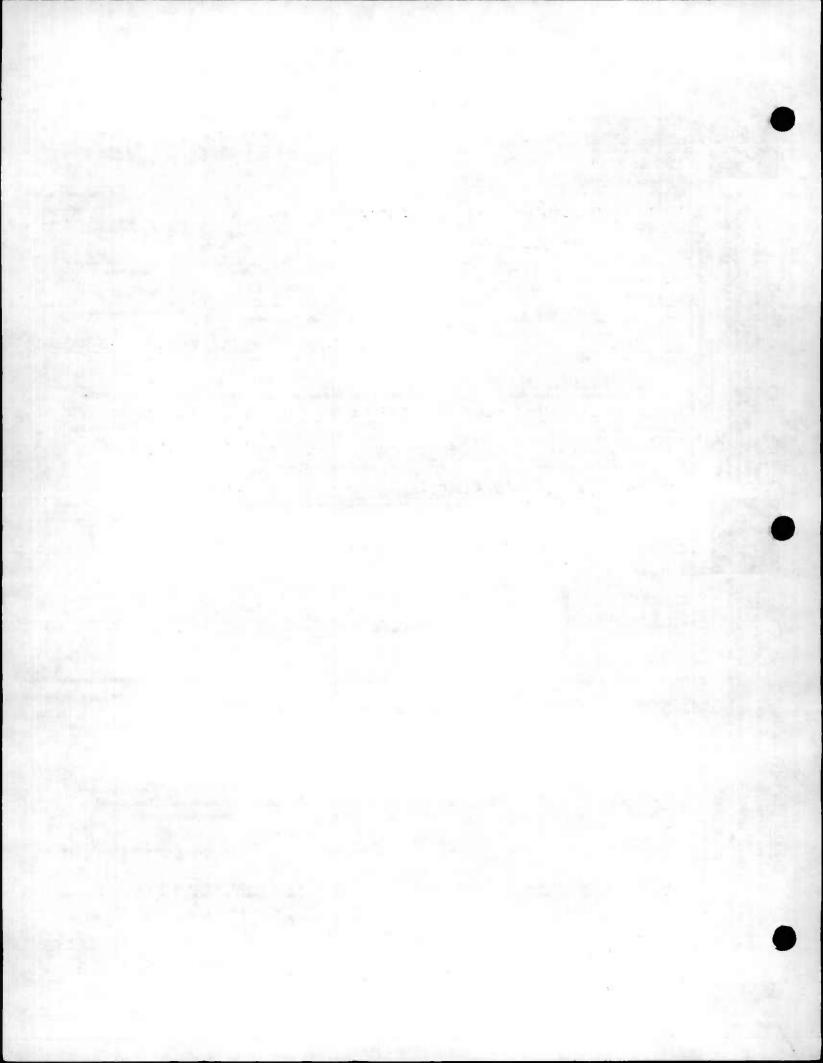
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and eddress of person who comple eted cause of death (Item 23a) (Type, Print) BLVD Saile 340 Mendhiralta Research 240

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signatura

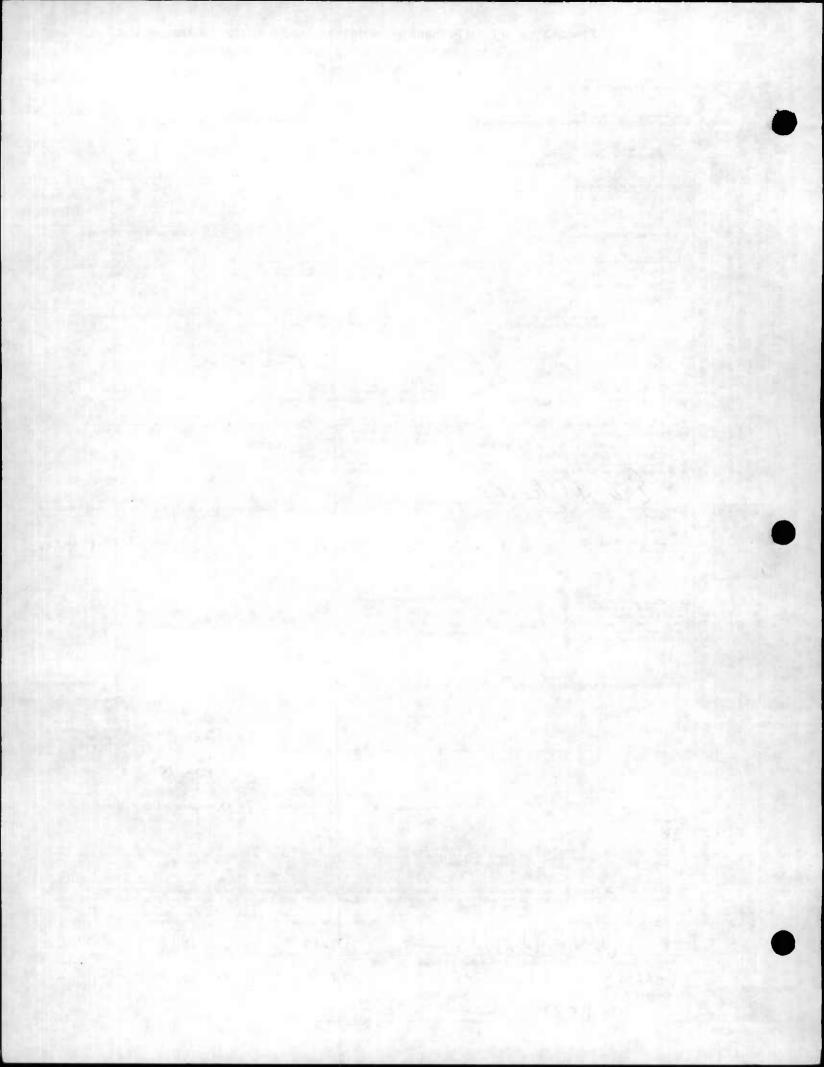


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State of Maryland / Department of Health and Mental Hygiene

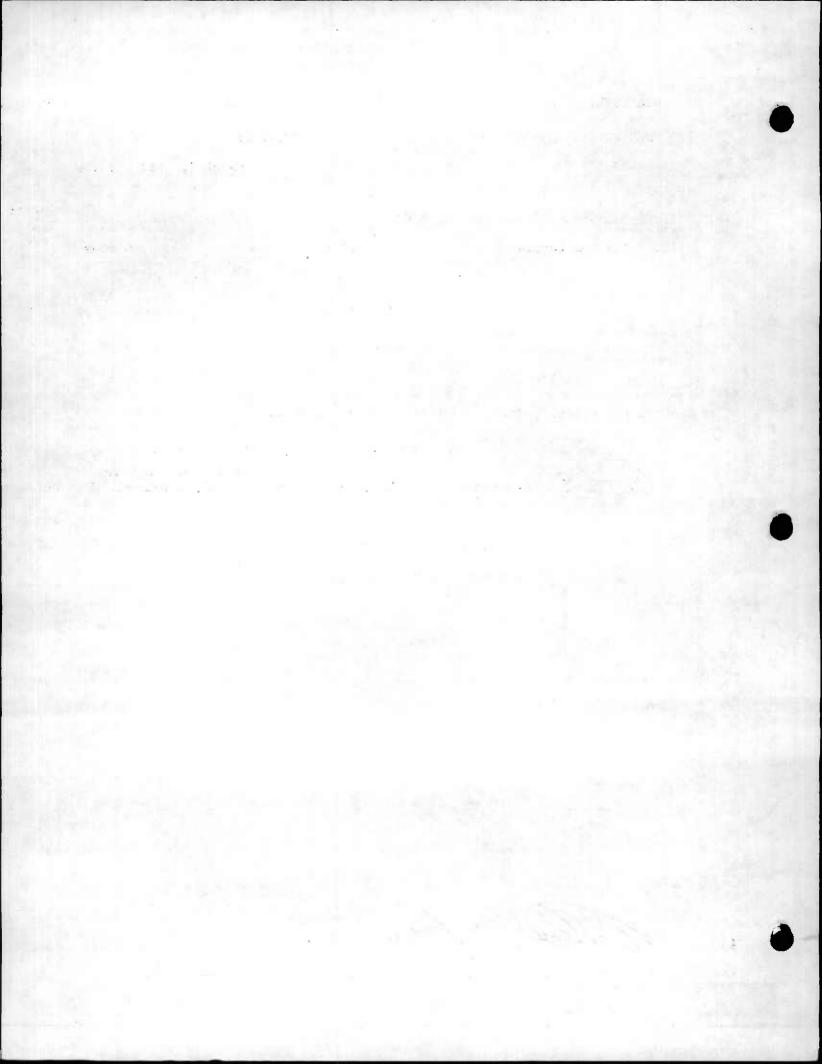
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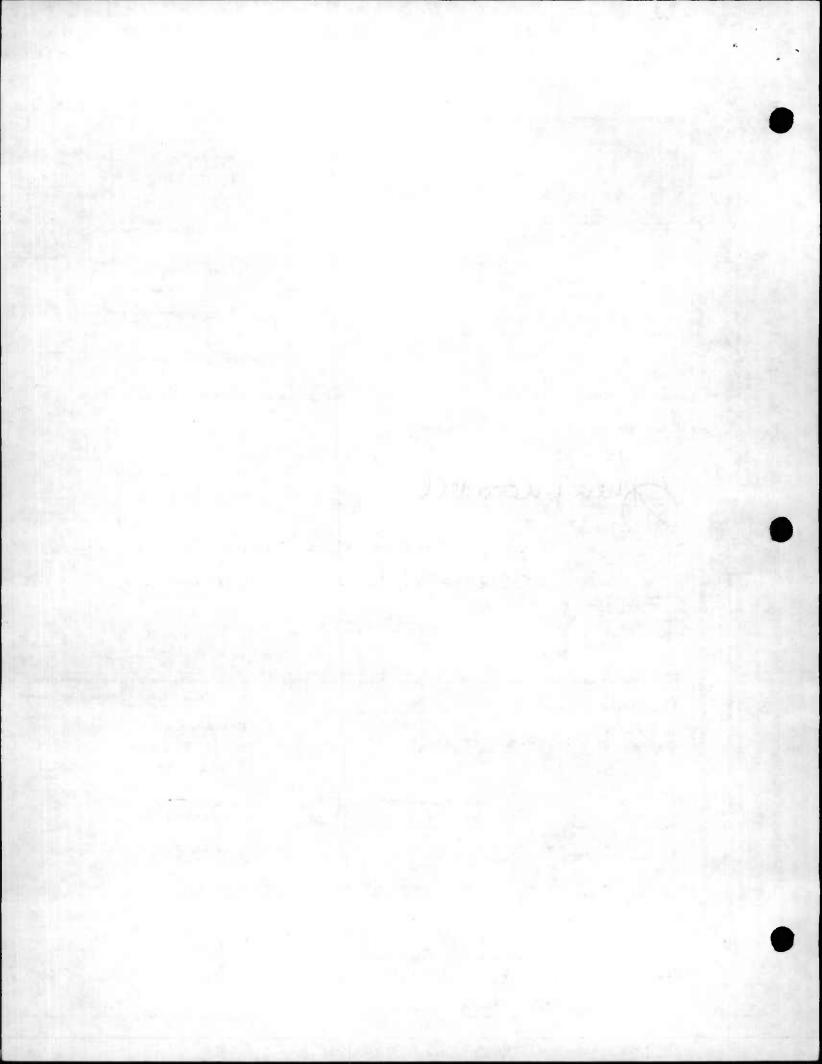
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niner			ive street and number)			4b. City, Town, or Loc			Death		
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	//	15. Decedent's E		16a. Dece	dent's Usual Occu	pation	•	16b. Kind of Busi	iness/Indus	try	
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		me (First, Middle, Las				18. Mother's Name					
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ŀ	Part II. Other si	gnificant conditions	contributing to death but	not resulting in the	inderlying cause gi	iven in Pert I.	23b. Dld	tobacco use conti	ribute to th	e cause of death?	
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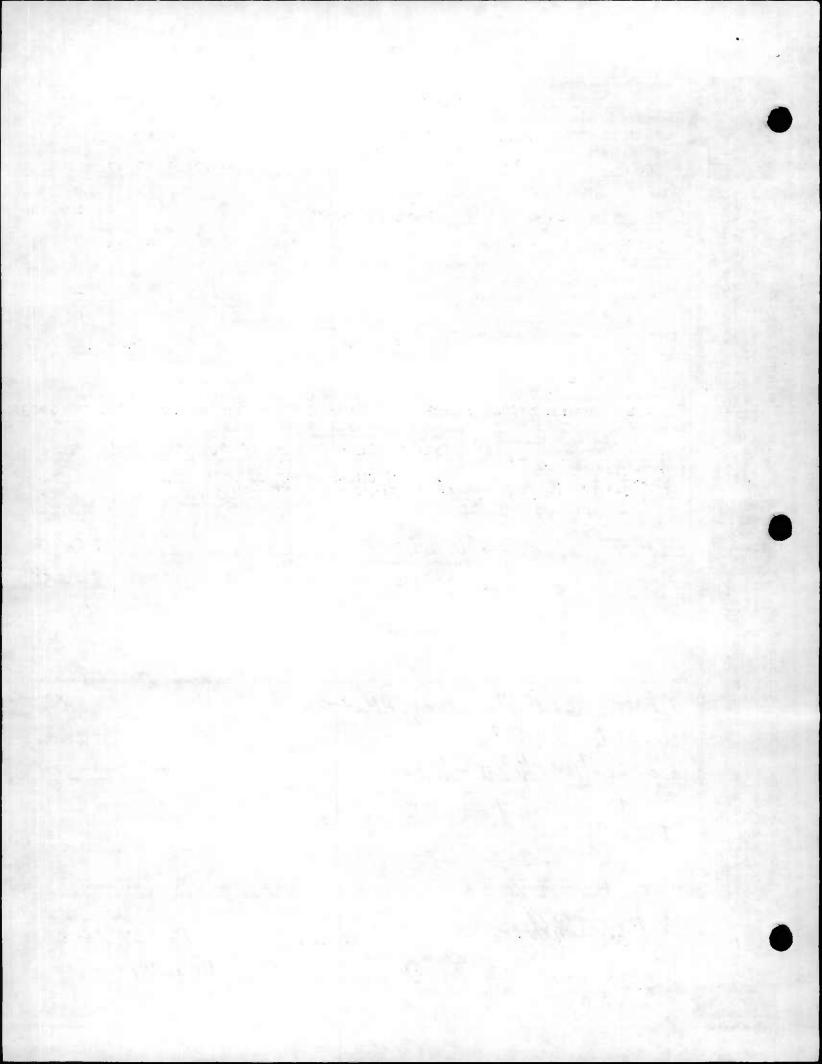
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible:

		State of Maryland / Department of Health a Certificate of Death		Reg. No.			
	Physiciar	Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Ye	3. Time of Death		
	/Medica	JEANNETTE REQUENA	APRIL	27, 2000	0929		
	Examine		wn, or Location of Deatl				
1-	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	VIIIE 24 Hrs. 8. Date of Bir	MONTGOM th 9.	ERY Birthplace (State or Foreign		
	Director	None 1 M 20 F 66 Yrs. Months Days Hours	Min. (Month, Da Dec. 3	th Year) 9.	Paris		
	ahow det	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits X☐ Yes 2 ☐ No		
	vith the Me or 28e-fa	MD Montgomery Montgomery Villa 100. Street and Number 100. Zip Code	ge	10g. Citizen of What			
	th with	9426 Fern Hollow Way 208	86	Franc			
020	72 hours after death with the Meryland natural; or items 23s or 28s-f show dies! Examiner must be notified at older.	3 Widowed 4 Divorced Year or Dates:	jin? (Specify Yes or No , Puerto Rican, etc.)	14. Raca - A Bleck, V Specify:	American Indian, Vhite, etc. White		
5-0	"natural", natural", natural hy	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	of working	16b. Kind of Busine	ess/Industry		
21215-0020	within she.	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) Elementary/Secondary (0-12) 6th Housewife		Hon	ne		
	FIEE a		18. Mother's Name (First, Middle, Maiden Surname)				
/lar	should be and marked or umatic eve	Jean Plot G	abrielle	Moriceau	1		
Maryland	P B B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)					
	Health tem 27 I	Chantal Aguilar (Daughter) 9426 Fern Hollo	ow way, M	20c. Location - City			
Baltimore,	pemit. Peges 1 and Department of Health Important: If Item 27 any Injury or other to	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **Community of the place) Metropolitan F/Serv					
Ball	Depart Import any in	21. Signature of Funeral Service Licensia 22. Name and Address of Facility SNOWDEN FUNE. ROCKVILLE, M.	RAL HOME,	P.A.			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock or heart failure. List only one cause on each line.		rrest,	Approximate Interval Between		
	Physician /Medical Examiner	Immediete Cause (Final disease or condition resulting in death) a. South C Shock			Onset and Death		
	<u> </u>	Due to (or as a consequence of):			3 u eeks		
	physician and s the burial-transit	Sequentially list conditions, Due to (or as a consequence of):			Jueens		
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Box	at the death certification of the attending elached for use as Physician/Me	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	23h Did	tobacco usa contrib	oute to the cause of death?		
P.0	ed by the detached				Probably 4 Unknown		
of Vital Records,	8 68 6		24a. Was	an autopsy 2-	4b. Were autopsy findings evailable prior to completion of cause		
Rec	0 - 0 -	Concestive Heat Failure	10	Yes alino	of death? 1 ☐ Yes 2 ☐ No		
ital	ysician: The is certificate director, per Co Be Co		of Death (Check only	one)			
> 5	2 00	1 Yes 20 No Hospital: 1- Unpatient 2 ER/Outpatient 3 DOA Other; 4 Nu	rsing Home 5 🗆 Resi	dence 6 Other (Specify)		
	After fune	27. Manner of Death 28a. Date of Injury 1—Phatural 5 Pending (Month, Day Year) 28b. Time of linjury 28c. Injury at Work? 1 Pending Month, Day Year) M 1 Yes 2		how injury occurred			
Division	Hospital or Attending P 24 hours after death. Funeral Director: After t stely filled in by the funeral of the funeral Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined	28f. Location (City or To		r Rural Route Number,		
	Hospi 24 hou Funer stely fill		d place, and due to the th occurred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)		
	Within To the comple			29d. Date signed (M	onth, Day, Year)		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print).	thenda 11	20817			
	State Registrar	MAY O A SHOOL E	THE THE				

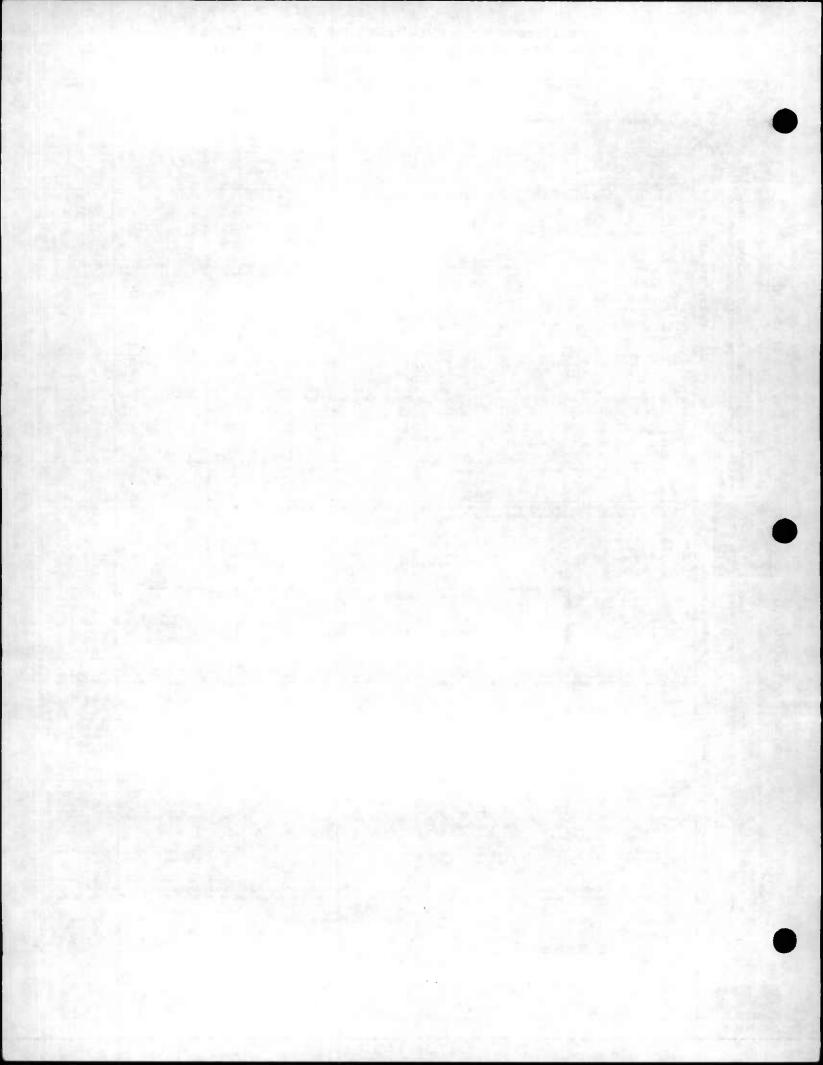
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State of Maryland / Department of Health and Mental Hygiene 1599

							Certi	ificate	e of i	Death			Reg. No.	1 600			
		1. Decedent's Nama (First, Mide	dle, Las	nt)		7	40		/4			2. Date of D	eath		W-222	3. Time	of Death
Physic		MELVIN RICHTER										Month APRIL	30, 2	000	Year	12:0	7 PM
/Medi		4a Facility Name (If not instituti	-	street and num	ther)					lb. City. To	wn, or L	ocation of Dea	-	County o		12.0	, 111
Examir	ner	SHADY GRO				HOSE	ATI	L				ILLE				MERY	
		5. Sociel Security Number	6. Se	-		yrs. last birt	-	If Under	1 Yaar	If Undar	24 Hrs.	8. Dale of B	irth		9 Birtho	lace (Ste	e or Foreign
Funeral Director		533.26.6654		Q M 2□F	83			Months	Days	Hours	Min.	8. Dale of B (Month, D JUNE 1	9, Year) 7, 19	16 N	Coun 1A	try)	e or Foreign
2 .	-	Usuat Residence of Decedent 10a. State 10b. Count	he		100	. City, Towr	or Loon	tion								Od Incide	City Limits
ath with the Maryla 23s or 28s-f shor sat be notified at	Director	MD MARY		D		BETHES		idon									es 2 No
4 80	F	10e. Street and Number	12114					10f, Zip	Code	8 80	10g. Citizen of What Cour				itry?		
N S S		6415 KENHOWE D	DTT	F					2081	R17			USA	USA			
ar death w Rame 23a Det must 1	Jer	11. Marital Status	71(1. 4.	12. Was Dece		in U,S.	13. Wa	as Deced	sent of H	ispanic Or	gin? (Sp	ecity Yas or N	10-		. Race - Amaricen Indian,		
Z1Z15-00Z0 d within 72 hours after des glens. r than "natural", or items if the Medical Examinar m	by Funeral	1 Nevar Married 2 Ma 3 Widowed 4 Divorce		Armed Forces? d 1 ∑Yes 2 □ No If Yes, Give Year or Dates:						v Cuban, Mexican, Puerto Rican, etc.) No Specify:			SpecifyWHT				
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Maryland d 2 should be fla th and Manual Hy 7 is marked othe traumatic event	To Be	MAX RICHTER		ROSE CA					CAS	STALINE							
T ST ST ST ST ST ST ST ST ST ST ST ST ST	-	19a. Informant's Name/Relation	ship (7	ype, Print)		19b.	Mailing	Address	(Street	and Numb	er or Rui	ral Route Num	ber, City or	Town, S	Stete, Zip	Code)	
and 2 and 2 ashth a n 27 is		LENORE R. RICH	ITER	WIFE		64	115 H	KENH	OWE	DRIVE	e, Bl	ETHESDA	, MAF	YLA	ND :	20817	7
Item 27		20a. Method of Disposition		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20	b. Placa of	Disposit	tion (Nar	ne of			Date	Т			wn, Slata	
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Sal and and and and and and and and and and		21. Signature of Funeral Service	e Licans	S00			22. N	Neme en	d Addre	ss of Fecili '타기 . FI	INER:	AL DIRE	CTION	J. TI	NC.		
		- Will										E, ROCK				AND	20852
		23a. Part1. Enter the diseese, o	or comp	lications that ca	used the d	deeth. Do n	not enter	the mod	e of dyin	g, such as	cardiac	or respiretory	errest,	11 . 2	1	Approxin	nete
Physician		shock, or heart failure. Lis	st only c	one cause on ea	icri line.											triterval I Onset ar	nd Death
/Medical		Immediate Cause (Finel disease or condition RESPIRATORY FAILURE												HOU	RS		
Examiner		disease or condition resulting in death)		a. RESPI											- 1	11001	
	6	Due to (or as a consequence of):										1	MON	PHS			
pe usit	듣			b. BRAIN	BIATH STEP STRONG							1110					
X 68/60, ertificate be executed sing physician and se as the bunsi-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as a consequenca of):													
68 / 60, flicate be ex physician as the burial	lca	that initiated events resulting in death) Last Due Io (or as a consequence of):										100					
ng p	Mec																
BOX 6	Par.	d									1						
. 0 0 %	Sici	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in								en in Part		23b. Die	i tobacco i	Jae con	tribute to	o the cau	se of death?
IS, P.C. BOX es that the death cer igned by the attendin be detached for use	Physician											10	Yes 2	∃ No	3 ☐ Prol	bably 4	∭ Unknown
S that gned be deter	by P																
requir requir	Completed b												s en eutop: formed?	зу	av.	aitebte pri	sy findings or to of cause
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VITAL Sicient The certificate irector, pag	Be	25. Was case referred to medic examiner?	-							26. Place	of Dea	th (Check only	one)				
	2	1 Yes 2 No		Hospitat: 1 ☐ tr	patient .	2 XER/Ou	tpatient	3 DC	Oth Oth	er: 4 🗆 N	ursing He	ome 5 Re	sidenca 6	Othe	or (Specif	y)	
on or offing Phys. h. After this funeral d		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	lina	28a. Date o	f Injury n, Day Yea		ime of	2	8c. Injur Wor	y at k?		28d. Describe	how tnjury	occurre	ed		
Attending or death.	atic		ligation				,,	М		Yes 2□	No						
DIVISION Tor Attending after death. Director: After d in by the fune	Certification:	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homtcide deter	d not be mined	289. Placa	of injury - /	At home, fe	rm, stree	t, factory	, office			28f. Location	(Street end	/ Numbe	er or Rure	A Route N	/um <i>ber</i> ,
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DIVISION To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	edical ((Check only 2 Medics	ing Phy I Exam	vaician: To the balliner: On the ball	sis of exan	knowledge nination and	, death o	occurred stigation,	et the tin	ne, date ar pinion, des	d place, th occur	and due to the	e cause(s) e, date end	and mer placa, e	nner as s	tated.	se(s)
thin the mple	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the ceuse(s) end manner stated. 29b. Signature and title of continuer 29c. License number 29d. Date signed (Month, Day, Year)										r)						
5.¥5.8		So. Signature and title disease		()	/	//		230	/		70	11	10	J		^	
12		Ville	~	X	ost	2	7		11	3.	SL	6/	MAI	2/	5	1 2	-000
-		30. Neme and address of person	n who c	completed cause	of death ((Item 23g/	Type, Pr	rint)								1	
		DR. WILLIAM I	COOL	EY, 990	1 MED	DICAL	CENT	TER I	DR,	ROCKV	ILLE	E, MARY	LAND	208	850		
Sta	ite	31. Dete filed (Month, Dey, Yea	_		gistrar's S		1	-									
Registr		MAY 0.3	20	nn 🔥	merca	1	9.	An	20 1/2	1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 3. Tima of Daath 1. Decadent's Name (First, Middle, Last) 2. Data of Daath RILEY, III **Physician** HENNETT 1445 D. MORIL 1000 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SIWER SPRIKE If Under 1 Yaar | If Under 24 Hrs. Birthplace (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F Yrs. 212-76-0300 43 Mar. 15, 1957 Maryland Director Usual Rasidanca of Dacadani with the Marylend 10c. City, Town or Location 10d. Inside City Limits ahow. 10a Stata 10b. County pernit. Pages 1 end 2 should be filed within 72 hours after death with the Maryle Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f ahow any liquiry or other traumatic event, ira Medical Examiner must be notified at ence. 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Directo 10g. Citizan of What Country? 10e Street and Number 10f. Zip Coda 14325 New Hampshire Avenue 20904 USA Funeral 14. Raca - Amarican Indian, Black, White, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 ☒ No If Yas, Give Year or Datas: 1 XNavar Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Unit Secretary Georgetown Univ. Hosp. 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Be Bennett D. Riley, Jr. Dolores Mabel McLean 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Dolores M. Riley / Mother 14325 New Hampshire Avenue, Silver Spring, MD 20904 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Darial 2 ☐ Cramation 3 ☐ Ramoval from State Parklawn Memorial Park 05/01/00 Rockville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Tunaral Sarvice Lice 22. Name and Addrass of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland Approximata Interval Between Onset and Death for the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. **Physician** HERATO-RENAL POILLES /Medical Immediata Causa (Final disaase or condition rasulting in daath) Examiner Due to (or es e consequance of): Examiner 560515 physician and s the buriel-transit thet the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or Injury that initiated events rasulting in death) Last Dua to (or as e consequance of): Couvits P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) 80 use 0 signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown CHOPIC HOPATITIS - C, STOOK FOLKETURE LFT. IT'S Records, 2 24b. Wara autopsy findings aveilable prior to 24a. Was an autopsy Completed complation of cause of death? is certificate hes director, pege 2 2 No 1 ☐ Yas 2 No 1 Yes Division of Vital Attending Physician: 25. Was casa referred to medical Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Has 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) this 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending SANTAN EOUS STABS FRATING efter deeth. 1 Yes 2 No CINKODWY investigation 3/17/200-2 Accidant 6 Could not be datarminad 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 281. Location (Straet end Number or Rural Route Number, City or Town, Stata) 14325 NON HAMBH26 NV 4 T Homicida Hospital or A
 A
 C4 hours efter
 Funeral Dire
 Inledy filled in b Home SILVER SPORT , MO 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi edical (Check only Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. S w and title of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) APRIL 27, 2000 0 15236 PME / 10 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

CHOL I. WALGOLIS, MO. (OME) 11125 BOCKVILLE BIKE, PROCKVILLE, MO 20852

Registrar

State

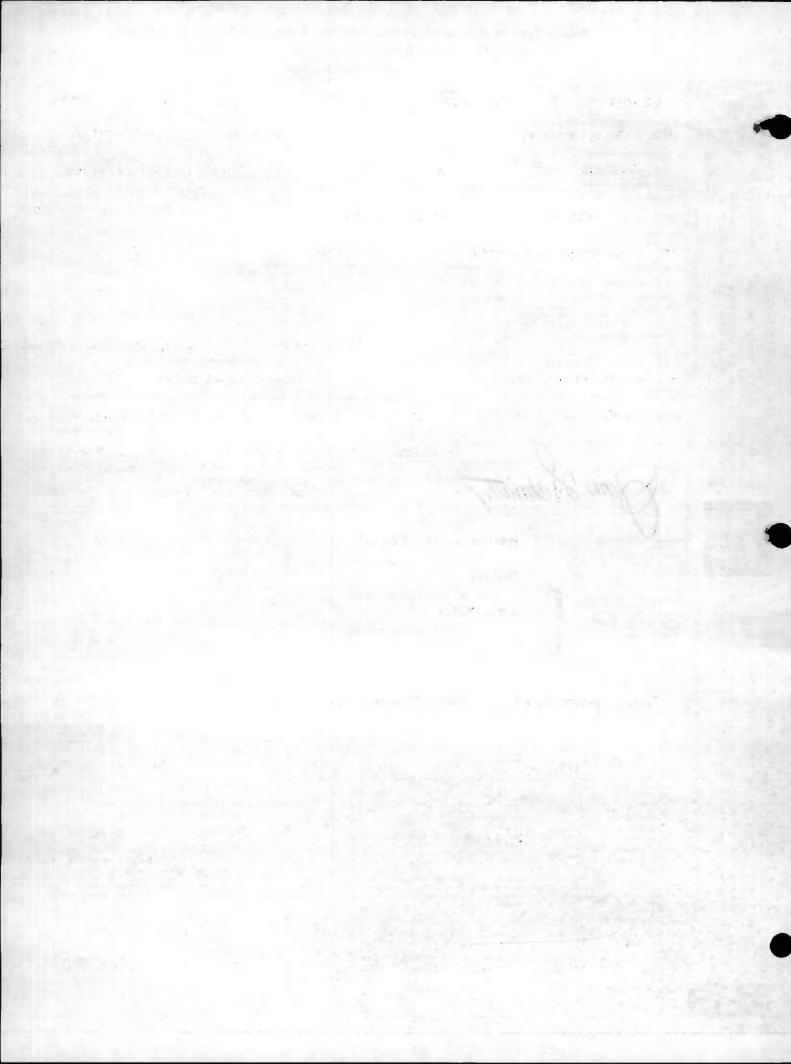
31. Data filed (Month, Day, Year)

MAY 02

2000

32. Registrar's Signetura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Daath 1. Decedent's Nama (First, Middla, Last) Day Month Yaar April 30, 2000 Christine W. Roe 3:40PM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 14601 Dodie Terrace Darnestown Montgomery If Under 1 Yaar | If Undar 24 Hrs. Birthplaca (Steta or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days 1 ☐ M 2 🖾 F Yrs. 521-72-7218 47 Kansas Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Montgomery Darnestown 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14601 Dodie Terrace 20878 United States 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Collega (1-4or 5+) Education Pre-School Director 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) Magdalena Gaertner George A. Waldorf 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) 14601 Dodie Terrace, Darnestown, Maryland 20878 Daniel M. Roe/ Husband 20b. Place of Disposition (Nema of camatary, cramatory or other place)
Boyds Presbyterian
Church Cemetery 20a Mathod of Disposition Data 20c. Location - City or Town, Stata May 4, 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 2000 Boyds, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Fecility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, M00689 Rockville, Maryland 20850-2805 Approximata Intarval Batwaan Onsat and Daath Fried the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, being failure. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting in death) Metastatic Breast Cancer l year Due to (or es e consequance of): Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events Dua to (or as a consequence of): thet initieted events rasulting in death) Last Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in tha undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Carcinomatous Meningitis 24b. Wera autopsy findings available prior to 24e. Wes en autopsy performed?

The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, Physician: Hospital or Attending

Examiner and physician the 88 957 à page after death.

Director: Aft
d in by the fur

Physician

/Medical

Examiner

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Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ent if Hem 27 is marked other than "natural", or ha

Hygiane.

Physician /Medical

Examiner

Maryland 21215-0020

Saltimore,

the Maryla

Physician/Medical by edicai Certification: To Be Completed

To the Hospital or Atte within 24 hours after de To the Funeral Directo complataly filled in by th 29b. Signatura and title of certifier

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	Was case refer	red to medical	26. Piece of Deeth (Check only one)												
	axaminar? 1 □ Yas 2 🙀	No	Hospital: 1 Inpatiant 2	ER/Outpatient 3□	DOA	Other: 4 Nursing H									
	Mannar of Death I ∰Natural 2 ☐ Accident	5 Pending invastigetion		28b. Time of Injury M	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Dascribe how in	d							
	3 Suicide 4 Homicide	6 Could not be datermined		oma, farm, straat, fac fy)	tory, of	fica	28f. Location (Street City or Town, Ste	and Number ata)	r or Rural Routa Number,						
296	Certifier (Check only one)		nysicisn: To the best of my kno miner: On the basis of axamina and mannar stated.												

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29c. Licansa number

29d. Date signed (Month, Day, Year)

May 2, 2000

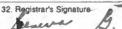
30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print)

George A. Sotos, M.D. 10605 Concord Street, #300, Kensington, Maryland 20895

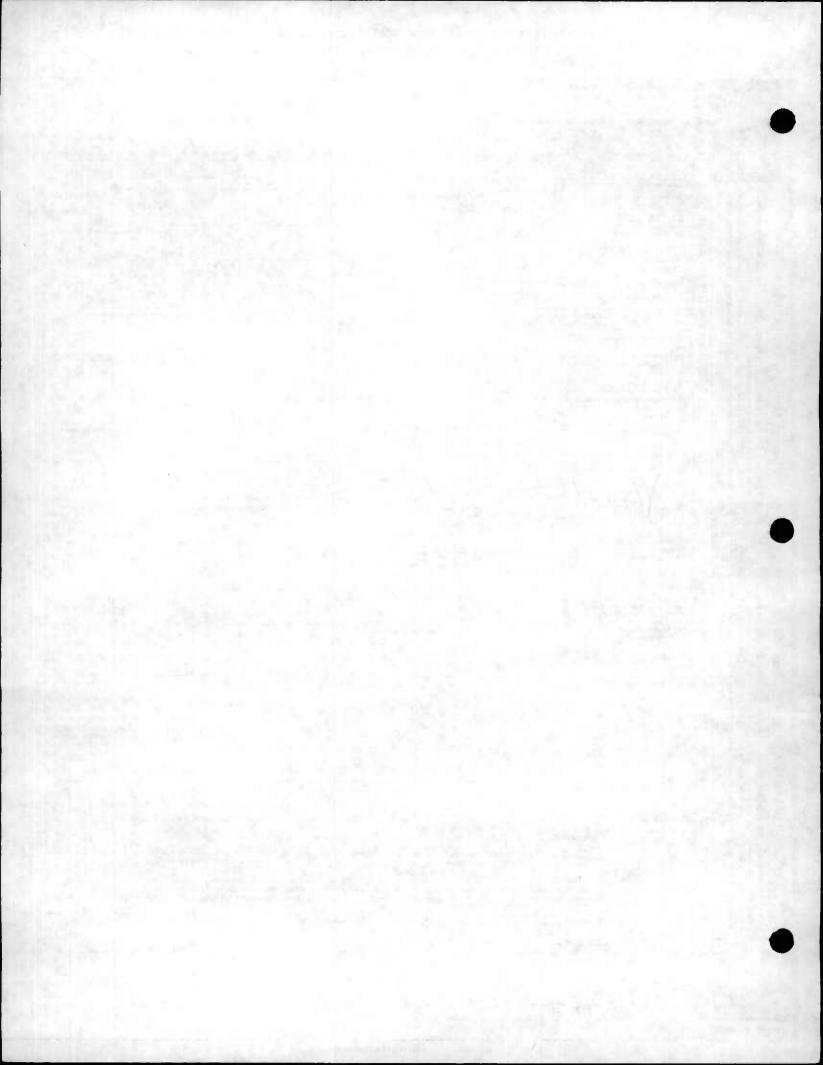
State Registrar

MAY 05 2000

31. Data filed (Month, Day, Year)







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Nama (First Middle Last) 2 Data of Deeth 3 Time of Death 30 Dey **Physician** Wanda Jane Rucker Month 04 2000 1332 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GROVE ADVENTIST HOSPITAL | Munder 1 Year ROCKVILLE MONTGOMERY SHADY 5. Social Sacurity Number 7. Age (In yrs. last birthday) 61 vre If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 10/19/1938 Birthplaca (Stata or Foreign Country) **Funeral** 1□M 201F Months Days Hours 166 32 3232 Altoona PA Director Usual Rasidenca of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f ahor MD Gaithersburg Montgomery XXYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Introduction: If them 27 is marked other than "natural", or itema 23a or 2 any injury or other traumatic evant, the Medical Examina and once. 877 Clopper Road #T3 20878 USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 Yas 2 Who Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11. Marital Status 14. Raca - Amarican Indien. Bleck, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Waitress 11 Restaurant 18. Mother's Nama (First, Middla, Meiden Sumama) 17. Fathar's Nama (First, Middla, Last) Raymond Feathers Mildred Eva Stouch 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Waller V. Rucker (husband) 877 Clopper Road #T3, Gaithersburg MD 20878 20b. Place of Disposition (Nema of cematary, crematory of other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Metropolitan Crematory 5/1/00 4 □ Donation 5 □ Othar (Specify) Alexandria VA 22. Nama and Addrass of Facility Advent Funeral & Cremation Services 21. Signatura of Furfaral Sarvice Licanse Modulal Falls Church VA 22046 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and for use as the buriel-transit Sequantially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disaase or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Box 68760. Hospital or Attending Physician: The law requiras that the death certificate be each hours after death.

Funeral Director: After this certificate has been signed by the attending physician Dua to (or as a consequence of): P.O. | ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was en autopsy performed? 1 Tas 1 □ Yas 2 □ No Division of Vital illed in by the funeral director, 25. Was casa rafarred to maxaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 5 Pending invastigation 1 Naturel 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and dua to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifiar To the 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) addrass of person who complate (Item 23p) (Type, Print). Rockville, MD 20850

State Registrar 31. Data filed (Month, Day, Year)

MAY 0 2 2000

2. Registrer's Signature

Sports

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death **Physician** Elizabeth 06:40 2 ton 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number Birthpleca (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1□M 20 F rigland December 15, 1910 Director unknown Usuel Residance of Decedent with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA filed within 72 hours after deeth 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 2 Merried 21215-0020 1 Yes 2 No þ 3 Widowed 4 Divorced Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental hygiene. Important: If item 27 is marked other than "nu any injury or other traumente event, the Mestions. Elementery/Secondery (0-12) College (1-4or 5+) 10 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Unknown Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20b. Place of Disposition (Name of cemetery, cremetory or other place)

20th Data

20c. Location - City or Town, State brathan Sampleri 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 Removal from Stata 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Liqu 22. Name and Address of Facility GHT Anatomic Gift For 23a. Part1/Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. It only one cause on each line. Lauri MD 20707 Approximata Intarvel Batween Onset end Death **Physician** METASTATIC BREAST CANCER Immediata Cause (Finel disease or condition resulting in deeth) /Medical Examiner Dua to (or as e consequence of) Physician/Medical Examiner use as the burial-trensit or Attending Physician: The law requires that the death certificate be assocuted Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Lest Due to (or as e consequence of): Box 68760, Due to (or es a consequence of) P.O. ate has been signed by the page 2 should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy 1 Yes 2 No 2 12 No 1 TYAS certificate of Vital funeral director, 25. Wes case raferred to medicat 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 DNatural 5 Pending investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and dua to the causa(s) end menner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 APRIL 27, 2000

State Registrar MEDICAL CTR DR ROCKVILLE MD

9707

32. Registrar's Signeture

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

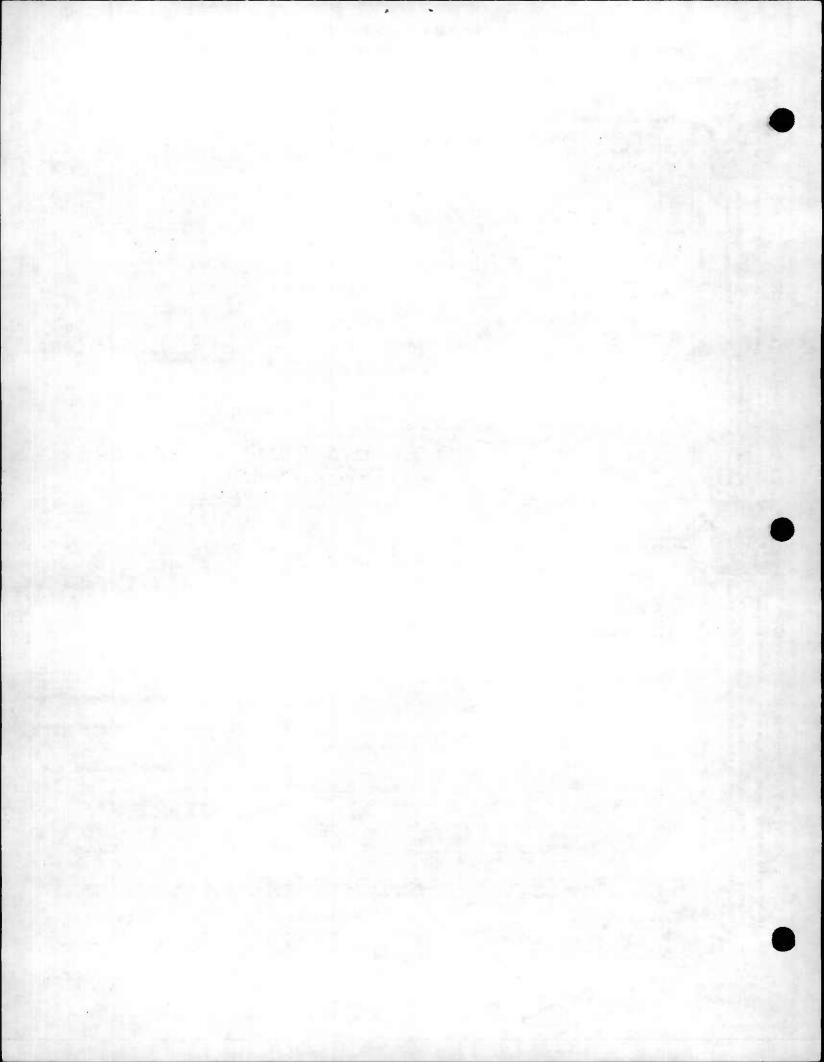
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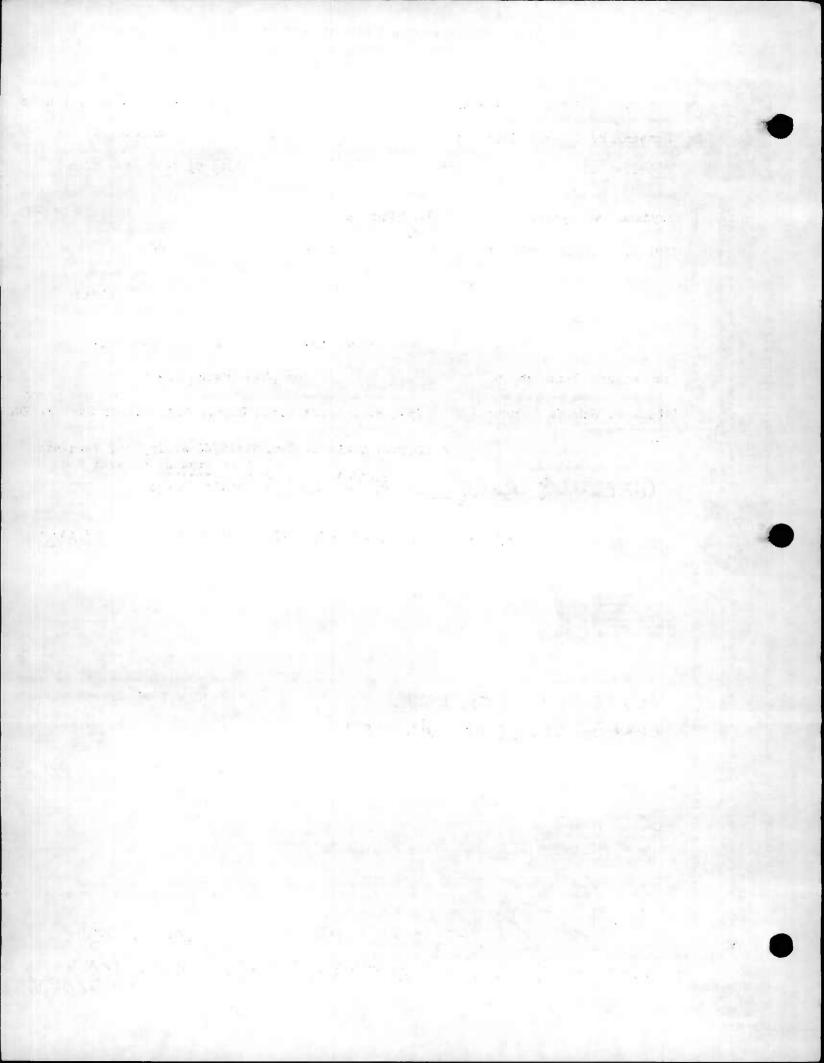
31. Date filed (Month, Dey, Year)

YMD



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, Last)	2. Date of Deal	eg. No. th	3. Tima of Death
Physician /Medical Examiner		Month	Dey Year 2000	
	Mary Grace Schwab	April wn, or Localion of Death	4c. County of Dealt	
	Montgomery General Hospital Olne 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under	24 Hrs 0 Date of Birth	Montgome	
neral ector	084-12-9508 1□ M 2□XF 78 Yrs. Months Days Hours Usual Residence of Decedent	Min. (Month, Day July 9,	1921 New	placa (State or Foreign intry) York
				10d. Insida City Limits
to	Maryland Montgomery Silver Spring	ing 1 yes 2 No		
Director	10e. Street and Number 10f. Zip Code	1	0g. Citizan of What Cor	untry?
a O	3501 S. Leisure World Blvd., #1A 20906		USA	
by Funeral	11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedant Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orl If Yas, specify Cuban, Mexican 1 □ Yes 2 □ No Specify:		14. Race - Amer Black, White Specify: Wh	
Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. Do NOT use retired)	t of working	16b. Kind of Business/i	ndustry
jdmo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker	Service Control of th		
Ü		er's Name (First, Middle, I	Name (First, Middle, Maiden Sumama)	
permit. Pages 1 and 2 should be filed within Department of Hashib and Mental Hygiene. Important: if item 27 is marked other than 's any injury or other traumatic event, the Menons. To Be Compile	John Robert Connaughton Josephine Katherine Hutton			
	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 20906			
	Albert N. Schwab / Husband 3501 S. Leisure World 20a. Method of Disposition 20b. Place of Disposition (Nama of		20c. Location - City or	
>	1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stale 4 ☐ Donation 5 ☐ Other (Specify) **Cemetery, crematory or other place)** Arlington National Cemetery, crematory or other place)**	m. 05/10/00 Arlington, Virginia		
9300	21. Signalura of Funeral Sarvice Licensee 22. Nama and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hamsphire Avenue Silver Spring, Maryland 20904			
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line.			
physician by Medical s the private and star and	Onset and Death			Onset and Death
	Immediate Cause (Finel disease or condition DAYS			
	resulting in deeth) Due to (or as e consequence of):			
E	Sequentially list conditions. Due to (or as a consequence of):			
EX	Sequentially list conditions, if any, leading to immadiate cause. Enler Underlying Cause (Disease or injury			
edicai Examiner	That to (or as a consequence of).			
Medi	resulting in death) Last			
Physician/M	Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death?	
/ Phys	ACUTE CHOLECYSTITIS		1 Yee 2 John 3 Probably 4 Unknown	
Completed by	CEREBROVASCULAR ACCIDENT	24a. Was a perfor	med?	Were autopsy findings availabla prior to completion of causa of deeth?
cartificate hes b rector, page 2 s		1 🗆 Y	es 2 No	I □ Yes 2 ₺ No
BeC	25. Wes case referred to medical 26. Place	e of Deeth (Check only o	ne)	
ToB	examiner?	ursing Home 5 Resid		cify)
cation: To Be	27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?	injury at Work? 1 Yas 2 No		
Medical Certification:	3 ☐ Sulcida 4 ☐ Homicide 6 ☐ Could not be determined 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	offica 28f. Location (Street and Number or Rural Routa Number, City or Town, State)		
edical (29a. Certifier (Check only and Check			
N	29b. Signature and the of certifier 29c. License number		29d. Date signad (Month, Day, Year)	
5	1 1 DAVA DORVE	DIRVED MANY 1 2000		MAG
	// / Vull 150 43	/ 1	VIM7 1) 6	
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) N. C. T. A. W. S. D. I. N. E. M. T. LONAL D. R. S. D	2 \$211,5	ILVER SPE	Me
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 0.2. 2000		001	120906



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month Eleanor Yeer 124 8 bara mar 2000 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 5/190 Spring Creek SILVER If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthpleca (Stete or Poreign Country) 1 □ M 2 🛱 F Months Days 60 290-32-8314 New York 13, 1939 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9039 Sligo Creek Parkway, #710 20901 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1K Never Merried 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Risk Management Consultant Health Care/ Nursing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Franklyn B. Siebelt Cecilia Ackerman 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 33710 Lynda C. Siebelt / Sister 1790 Devonshire Drive North, St. Petersburg, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 5/6/00 Silver Spring, MD 22. Name end Addrass of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Ligaritie Cer 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es a consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Undarlying Cause (Diseese or Injury that initieted events rasulting in deeth) Lest Due to (or es e consequenca of): Dua to (or as e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

Physician /Medicai **Examiner**

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be 2

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examinat must be noticed at 2006s.

Baltimore, Maryland 21215-0020

ettending physician and for use es the buriel-transit ed by the detached 2

The lew requires that the death certificate be executed

Records, P.O. Box 68760,

of Vital

Division

Physician/Medical Examiner þ Completed tal or Attending Physician: The state death.
el Director: After this certificate led in by the funeral director, pa Be Certification: To

29a. Certifier

25. Wes casa referred to medical exeminer? 1 Yas 2 No 27. Menner of Deeth

Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Date of Injury (Month, Dey Year) 28b. Time of

28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

26. Plece of Deeth (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only 29b. Signetura and title of cartifier

W MO OME

29c. Licansa number

29d. Data signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) BRECHER , mo DME

State Registrar

Medical

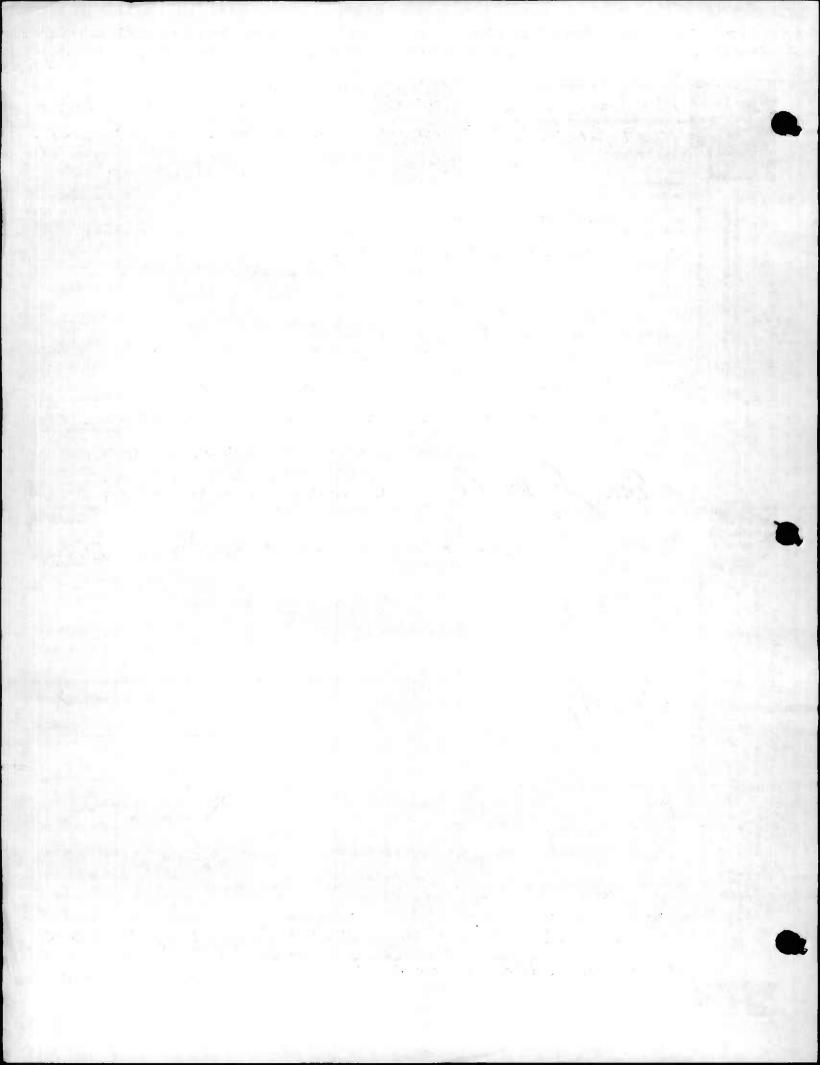
31. Dete filed (Month, Dey, Year) 2000 **MAY 04**

32. Begistrer's Signeture

To the Hospital within 24 hours e

completely

D



Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

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Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Manyland Department of Health end Mental Hygiane. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lulyry or other traumatic event, the Medical Examinar must be notified at PDE.

Baltimore, Maryland 21215-0020

attending physician end for use es the buriaf-transit The law requires that the death certificate be executed been signed by the should be detached cate has to is cartificate h diractor, page Hospital or Attending Physicien: this After this daath. within 24 hours after death To the Funeral Director:, complately filled in by the

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

by

Be Completed

Certification: To

Medical

State

29b. Signature and title of o

31. Date tiled (Month, Day, Year)

MAY 03

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

32. Ragistrar's Signature

JOSEPH SPOSATO, LT, MC, USNR

2000

immediate Ceuse (Finel disease or condition	a METASTATIC	CANCER			12 years
resulting in death)		or as a consequence of):			12 years
	b				
Sequentially list conditions, if any, leeding to immediate	Due to (or as a consequence of):			
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (c	or as a consequenca of):			
	d				
Part II. Other significent conditions	contributing to death but not re-	sulting in the underlying o	ause given In Part I.	23b. Did tobecco use co	entribute to the cause of deet
				1 ☐ Yes 2 No	3 Probably 4 Unkno
				-	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				24a. Was an autopsy performed?	completion of cause
25. Was case referred to medicel			26. Place of De	performed?	available prior to completion of cause of death?
25. Was case referred to medicel examiner? XYes 2 No	Hospital: 1 (Xapatient 2	☐ER/Outpatient 3☐ DC	Other	performed?	available prior to completion of cause of death? 1 □ Yes 2X No
examiner?	28a. Date of Injury (Month, Day Year)		Other	performed? 1 Yes 2□ No eath (Check only one)	available prior to completion of cause of death? 1 Yes 2 No

29c. Licensa number

97-01873

NATIONAL NAVAL MEDICAL CENTER

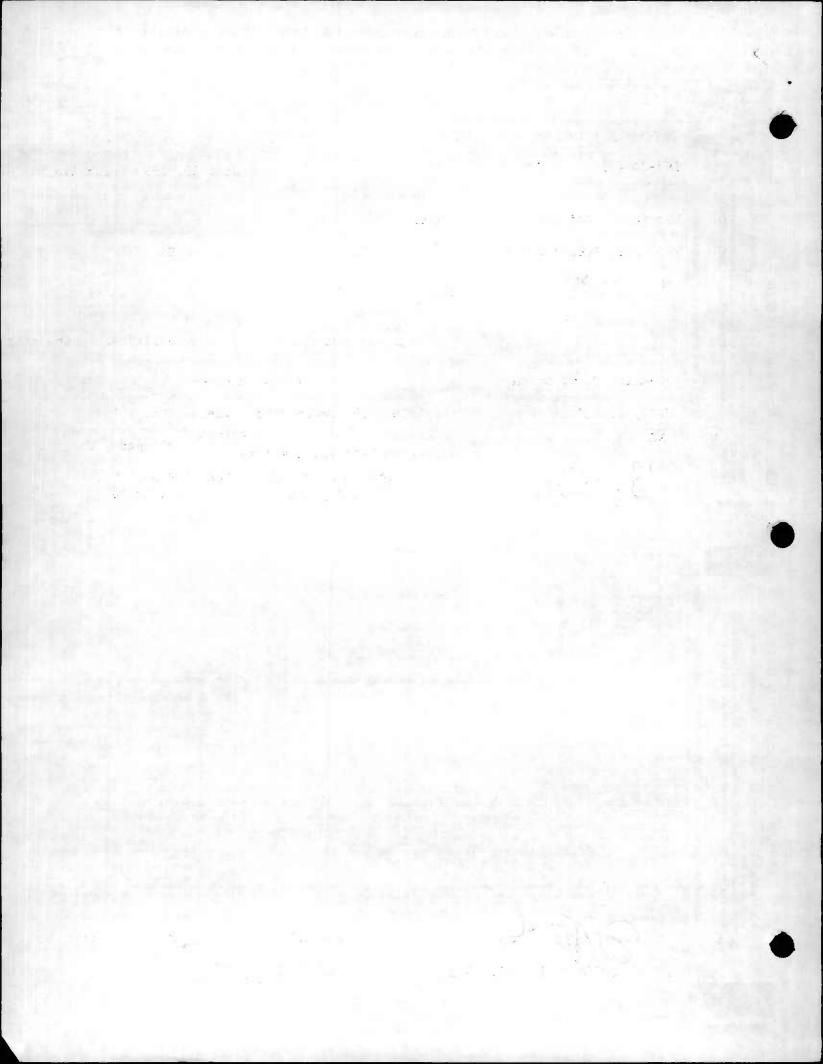
BETHESDA MD 20889-5600

29d. Data signed (Month, Dey, Year) 29

2000

APR

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3 Time of Death Month April 28, 2000 **Physician** 12:48 PM Warren A. Spero /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Rethesda Montgomery Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Solution of Birth (Month, Day, Year) Nov. 28, 1949 Birthplece (State or Foreign Country)
 Ohio 5. Social Security Number **Funeral** 1 1 M 2 □ F 200-40-9574 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Potomac 1 ☐ Yes 2 ☒ No Montgomery Maryland 28a-f Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 20854 14 Cherbourg Court United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 11. Marital Status Was Decedent Ever in U,S. Armed Forces? id be filed within 72 hours after de ental Hygiene. Ned other than "natural", or litem to event, the Medical Examiner. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Real Estate permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked offly any fillury or other treumstic event and. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Hazel Smith Wilbur Spero 19a. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valeria L. Spero/Wife 14 Cherbourg Court, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 29, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2000 Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 21. Signeture of Funeral Service License M00198 23a. Pert F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical 6 days Sepsis Examiner Due to (or as a consequence of): 4 weeks Physician/Medical Examiner Lymphoma use as the burial-transit law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 4 weeks Box 68760, Acquired Immuno Deficiency Syndrome that initiated events resulting in death) Last Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by page 2 should be detact 1 Yee 2₺ No 3 Probably 4 Unknown Renal Insufficiency, Neutropenia Records. þ 24b. Were eutopsy tindings available prior to Completed 24e. Was en eutopsy completion of cause of death? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 ANatural 5 Pending after death, Director: Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Breut a. Bergy, UD. April 28, 2000 D37840 10 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)
Rrent A. Berger, M.D. 11125 Rockville Pike, #103, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

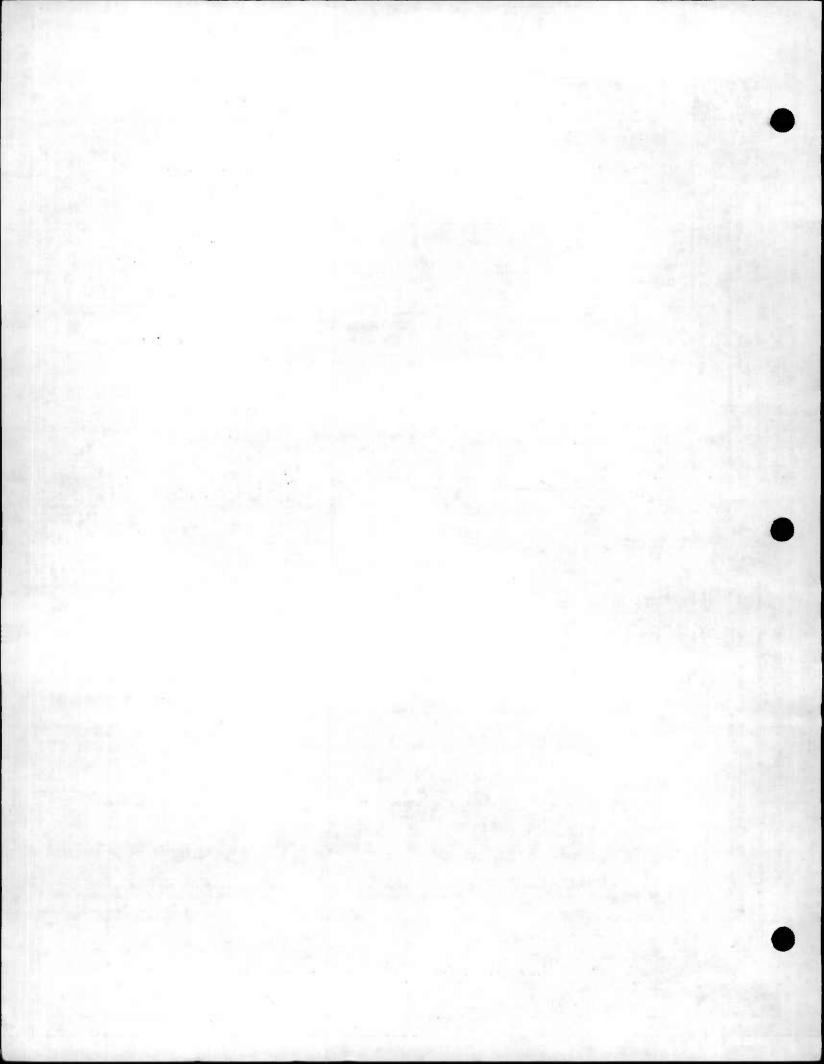
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2000

4/29/00

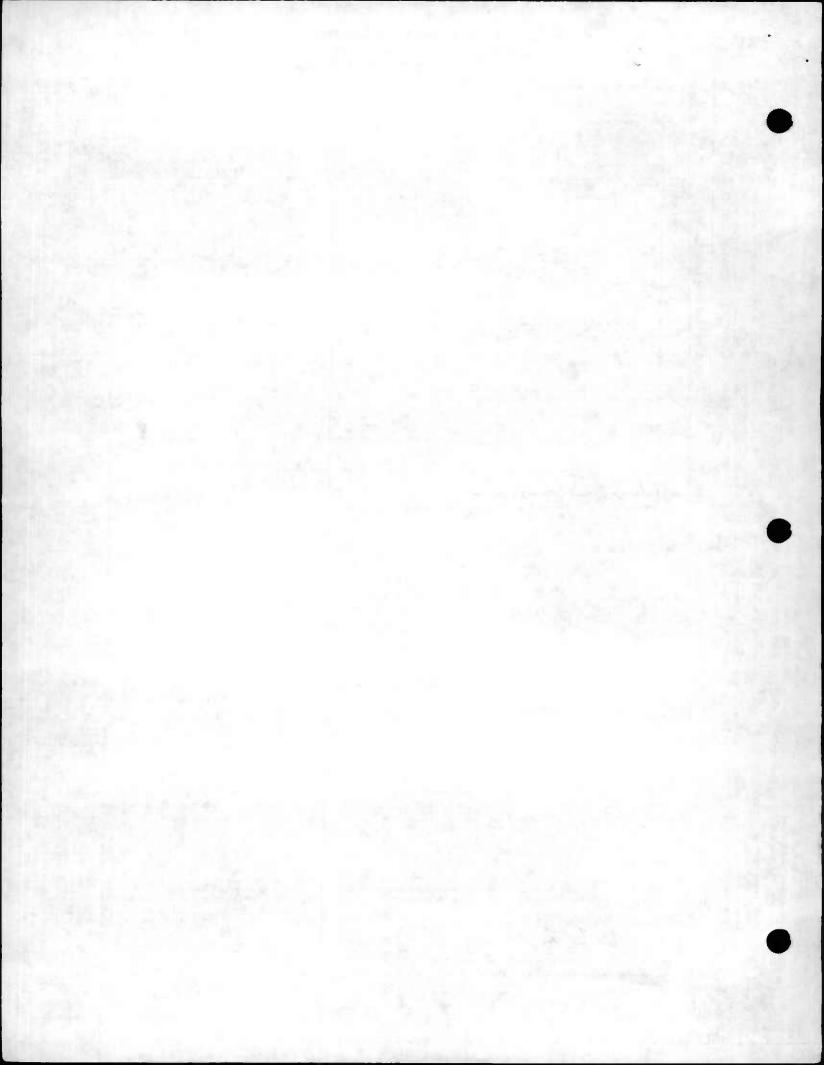
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		Certi	ficate of	Death	,	Reg. No.	
Physician	1. Decedent's Neme (First, Middle, Last) Doris Blake Stanley				2. Dete of Dee	Dey Ye	3. Time of Dee
/Medical Examiner	4e Fecility Name (If not institution, give street and number)			b. City, Town, or L	1 -	4c. County of I	1:32 P.
LAdillinei	Manor Care Potomac		- 47	Potomac		Montgo	merv
Funeral Director	098-20-6741 1□M 2KF		If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De) Feb. 24	h 9	Birthplace (State or For
MA W	Usuel Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Local	tion			VIV.	10d. Inside City Lii
Mary Hear	MD Montgomery	Potomac					1 TyYes 2
or 28a-f s	10e. Street and Number		10f. Zip Code			10g. Citizen of Whe	et Country?
23a o a 23a o	10714 Potomac Tennis Lane		20854		1000	United Sa	tates
72 hours after death with the maryland natural", or items 23e or 28e-f show diest Examiner must be notified at sted by Funeral Director	11. Mental Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Eve Armed Forces? 1 Yes 2 No H Yes, Give Year or Detes:		s Decedent of Hes, specify Cube	lispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. Black
	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	16a. Deceden (Give kin life. DO	nt's Usuel Occup ad of work done NOT use retired	ation during most of work d)	cing .	16b. Kind of Busin	ess/Industry
	17 Febbora Name (First Affeldin Leat)	Syst	ems Ana	_	a /First Middle	Computer	rs
m	17. Father's Name (First, Middle, Last)		45			Maiden Sumame)	
mant of the lith and Monte and I feel and Monte ant: If item 27 is marked iury or other traumatic er	John A. Blake 19e. Informent's Neme/Relationship (Type, Print)	19b Mailing	Address (Street	Rose Ac		r, City or Town, Ste	ate. Zip Code)
Ith an It	Karen Williams/Daughter					llville,	
T Hear	20e. Method of Disposition	20b. Plece of Dispositi cemetery, cremet	on (Neme of		Dete	20c. Location - Cit	
T E E E	1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	Harmony Me		1-	1ay 1, 2000	Landover	, Maryland
Department of Himportant: New York of the any Injury or off parts.	21. Signeture of Funeral Service Licensee	740	lame end Addre		e, N.W.		, , , , , , , , , , , , , , , , , , , ,
7	23a. Pert1. Enter the disease, or complications that caused the shock, or heart feiture. List only one cause on each line.					rest,	Approximete Intervel Between
hysician /Medical xaminer	Immediate Ceuse (Finel disease or condition a. Metas resulting in death)	static Brea		er			Onset end Deetl
<u> </u>	Due	e to (or es e conseque	nce ol):				
e attending physician and address as the burial-transit sician/Medical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated grants)	e to (or es e consequer					
d by the attending letached for use a Physician/Mo	Pert II. Other significant conditions contributing to death but n	ot resulting in the unde	erlying cause giv	en in Pert I.	23b, Did t	obacco uae contri	bute to the cause of de
ed by the	Alzheimer's disease				10	res 2□No 3	Probably 41 Unk
cate has been signed by the page 2 should be deteched Completed by Physic						en eutopsy med?	24b. Were eutopsy lindin evaileble prior to completion of cause of deeth?
page 2					101	res 2⊠No	1 ☐ Yes 2 ☐ No
s certificata director, par To Be Co	25. Wes case referred to medicat examiner?			26. Place of Dee	th (Check only o	ne)	
flee death. Nrector: After this in by the funeral di rtification: To	1 Yes 2 No Hospitel: 1 Inpatient 27. Manner of Death 1 X Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury (Month, Dey Ye) 28e. Plece of Injury building, etc. (5	- At home, lerm, street	M 28c. Injur Wor 1	4.61 Nursing H	28d. Describe I		
within 24 hours a To the Funeral C completely filled Medical Ce	29e. Certifier (Check only one) 1 Certifying Physician: To the best of mx and menner stated	aminetion end/or Inves					
within To the compl	29b. Signature and title of certifier m	7	29c. Licens			29d. Dale signed (I	
	30. Name and address of person who completed cause of death William A. Condrell, M.D. 4	h (Item 23a) (Type, Pri 910 Mass.	Ave. N.	W. Suite	#312 W	ashington	
State Registrar	31. Date tiled (Month, Day, Year) MAY 02 2000 32. Registrer's		Spark	.,			

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

An	nend #18,5	5/4/2000,BMW,Montq		nd / Department of Certificate of		ental Hygiene Reg. No.	UU 13	5919
	Physician /Medical	1. Decedent's Name (First, Middle, Le	ist)	STASINO	ULIAS	2. Dete of Deeth Month Dey MAY 2	, 2000	3. Time of Deeth
	Examiner	4e Fecility Neme (If not institution, given SUBURBAN	re street end number) HOSPITAL		4b. City, Town, or Lo		County of Deeth MONTGON	ŒRY
	Funeral Director	389-60-5838	6ex 7. Age (In yrs. 70	Yrs. If Under 1 Ye		8. Dete of Birth (Month, Dey, Year) DEC 31,10		lece (State or Foreign try) GREECE
	show start	Usuel Residence of Decedent 10a. Stete 10b. County		ty, Town or Location			1	0d. Inside City Limits Ñ☐ Yes 2☐ No
	vith the Ma or 28s-f s be redired	GREECE NON 10e. Street and Number	E	PYRGOS 10f. Zip Cod	8	10g. Citi	izen of Whet Coun	
20	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or thems 23e or 28e-f show ent, the Medical Examiner must be recitined as e.Completed by Funeral Director	S.P.A.P. 4 11. Meritel Stetus 1 Never Merried 2 Merried	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 277 No If Yes, Give—**	J.S. 13. Was Decedent of if Yes, specify C	NONE of Hispanic Origin? (Speuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	GREECE 14. Raca - America Black, White, of Specify:	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", any Injury or other treumstic event, m. Medical Exited DOGS. To Be Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12)		life. DO NOT use ret	ne during most of workii ired)	16b. Ki	ind of Business/Ind	
	ges 1 and 2 should be filed within 72 hi t of Health and Mental Hygiene. If fem 27 is marked other than "natur or other treumatic event, the Madical To Be Completed	17. Father's Neme (First, Middle, Last	KAPSASKIS	SEAMS!	18. Mother's Name	(First, Middle, Maiden PENELOPE	SEWING Sumeme) Kagioro KARACIOI	
Maryland	nd 2 should laith and Meni 27 ie merker f treumstic	19e. Informent's Neme/Reletionship (JOANNE STASINOU	Type, Print)	19b. Melling Address (Street) 14211 BRADLE	eet end Number or Rura	l Route Number, City o	r Town, Stete, Zip	
Baltimore,	Pages 1 and 2 nent of Health a ant: If Item 27 is ury or other tre	20e. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Special	Removel from Stete	Plece of Disposition (Name of cametery, cremetory or other) PTTALION CEME!	oleca)	Dete 20c. Lo	ocation - City or To	
Balt	permit. Pag Department important: It eny injury o	21. Signeture of Funeral Service Line	and have of	22. Name end Ad				
Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Physician/Medical Examiner	23a. Pert1. Enter the diseese, or com shock, or heert feilure. List only Immediate Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest	e. HEPAT Due to (or c. Due to (or d.	TIC FAILU or es e consequence of): TIS C or es e consequence of): or es a consequence of):	RE			Approximete Interval Between Onset and Deeth
, P.O.	as that the digned by the be detached by Physic	Part II. Other eignificant conditions of GASTOLO INTEST	INAL HEMOR		16 ULOPATI			pebly Unknown
Records,	aw requires to should 2 should pleted	RENALFAIL	UPE			24a. Wes en eutop performed?	eve	ere eutopsy findings eilable prior to mpletion of cause death?
Vital R	clan: ector ector	25. Wes case referred to medical exeminer?	Hospitel:		26. Piaca of Deeth	(Check only one)		Yes 2 No
of	or Attending after death. Director: After in by the fune ertification	1 Yes 2 No 27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide 4 Homicide 1 Ves 2 No 5 Pending Investigation 6 Could not b determined	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M 1	ijury et 2 No	ne 5 ☐ Residence (c) 28d. Describe how injure 28f. Location (Street an City or Town, Stele	ry occurred	
	To the Hospital within 24 hours To the Funeral completely filled Medical Co	ane) 2 Medical Exam	ysician: To the best of my known interest on the basis of examinet and menner steted.	otion end/or investigation, in m	y opinion, death occurre	ed at the time, date end	plece, and due to	the cause(s)
D	8	30. Neme and addresslot person who	MD con pleted cause of deeth (Item	02	26571	29d. Day	signed (Month, I	
	State	31. Date filed (Month, Dey, Year)	MIZUS N 32. Registrer's Signe	M.D. 4930	DEL RAY I	AVE #301,	BETHESE	20814 DA, MD.
	Registrar	MAY 0 4 20	00 seneva	D. spark	2			

DHMH 16 Rev 6/9

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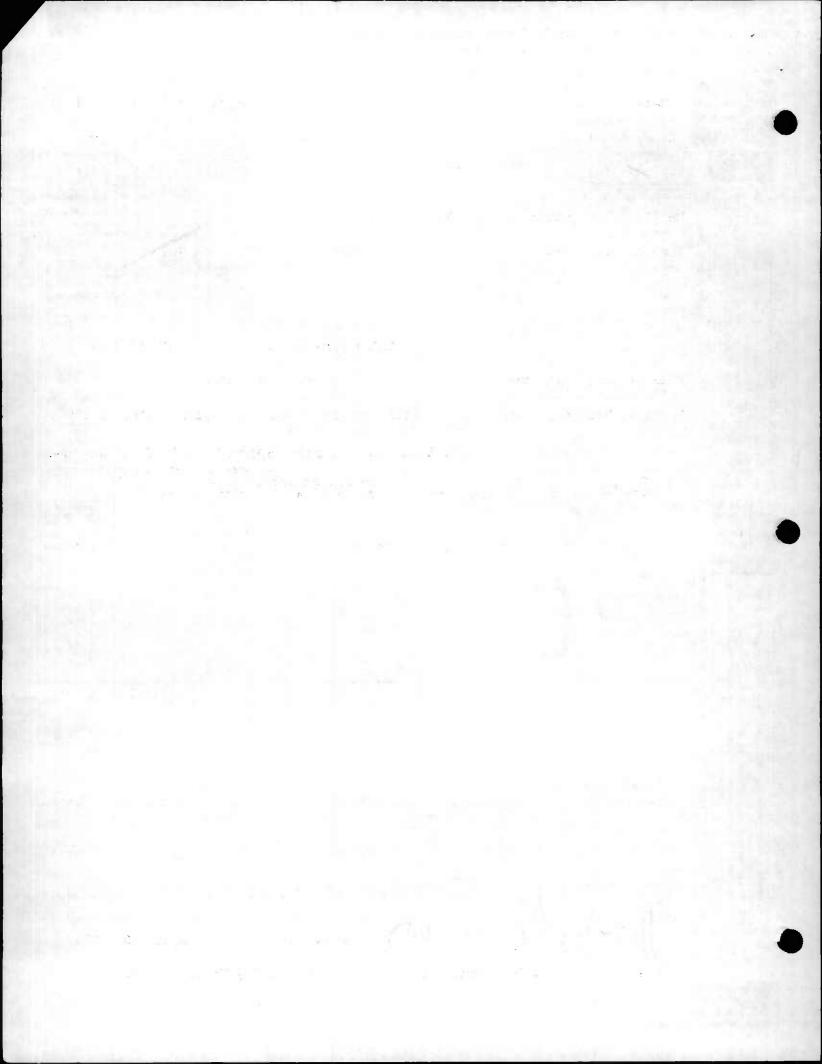
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #5,5/8/2000, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth April **Physician** 30^{bey} Hazel Sterling 2000 1:35 AM /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Casey House Rockville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthday) if Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months Deys 1□ M 2☑ F Director 24-5804 80 24, 1919 Virginia Usuei Residenca of Decedent with the Meryland 10b. County show 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 21 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3003 McComas Avenue 20895 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bieck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: à Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Child Care Provider 11 Child Care 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Wade Hampton Copenhaver Stellamay Lineweaver 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) Louis W. Sterling / Son 21401 Montgomery Avenue, Laytonsville, MD 20882 20a. Method of Disposition 20b. Piece of Disposition (Neme of Dete 20c. Locetion - City or Town, Stete cemetery, cremetory or other place) 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removei from State 4 Donetion 5 Dother (Specify) Parklawn Memorial Park 5/3/00 Rockville, Maryland 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervai Between Onset end Deeth Physician Immediete Ceuse (Finel diseese or condition resulting in death) /Medical Non-Hodgkins Lymphoma 9 years Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed attending physician end for use as the bunal-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760. Due to (or es e consequence of): P.O. ed by the a Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2€ No 3 | Probably 4 | Unknown s certificate has been signed I director, page 2 should be det Records, þ Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilebie prior to completion of cause of deeth? certificate 1 ☐ Yes 21 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ♣ Other (Specify) 10 Hospice After this in by the funeral 28e. Dete of injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 5 Pending Investigation 1 Neture 24 hours after death. 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. within 24 hours To the Fune completely fi 2 Medical Examiner: On the basis of exemination end/or Investigetion, In my opinion, death occurred at the time, date and piece, and due to the cause(s) manner stated. To the 29b. Signature and title of de 29c. License number 29d. Date signed (Month, Dey, Yeer) 10 D0037620 April 30, 2000 12 d alidress of person who completed cause of deeth (item 23e) (Type, Print) Mark S. Godec, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 31. Dete filed (Month, Day, Year) Begistrer's Signeture State

Registrar

MAY 02

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Dey **Physician** 29, April 2000 Mildred R. Stevens 5:30 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Gaithersburg Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) April 23,1905 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys 1 M 2 XF Yrs 95 577-03-6361 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 211 Russell Avenue # 404 20877 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: f Yes, Give Year or Dates: Specify. White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Edward F. Rowzee Edith Rollins 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) David W. Stevens, Jr./ Son 2524 Tudo Court, Annapolis, MD 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriat 2 □ Cremetion 3 □ Removel from Stete Parklawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 5/2/00 Rockville, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home, Inc. 2000 500 University Blvd., W, Silver Spring, MD 20901 infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) lears Physician/Medical Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequença of) Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ۵ Be Completed Medical Certification: To

The law requires that the deeth certificete be executed for use as the bunal-transit Division of Vital Records, P.O. Box 68760, signed b certificate Hospital or Attending Physician: this To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral (

Funeral

Director

Physician

/Medical Examiner

				H		24a. Wes en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of deeth?
						1 Yes 2 □ No	1 Yes 2 No
25. Was case refer	red to medical				26. Place of Dee	th (Check only one)	
axaminer?	HO	Hospitat: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DO	A Other: 4 Hoursing H	ome 5 Residenca 6 □Otl	her (Specify)
27. Manner of Deat 1 ☑Netural 2 ☐ Accident	5 Pending investigation		28b. Time of tnjury	M 21	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occu	rred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of Injury - Ath building, etc. (Speci		fectory	, office	28f. Location (Street end Num City or Town, Stete)	ber or Rurel Route Number,
29e. Cartifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowner: On the basis of examina	owledge, deeth oc ation and/or invest	curred e	et the time, date and place in my opinion, deeth occu	, end due to the ceuse(s) end m rred at the time, dete end place,	enner as stated. , and due to the ceuse(s)

D schulman

29b. Signature and the of certi

29c. License number 29d. Date signed (Month, Dey, Year) 205/6

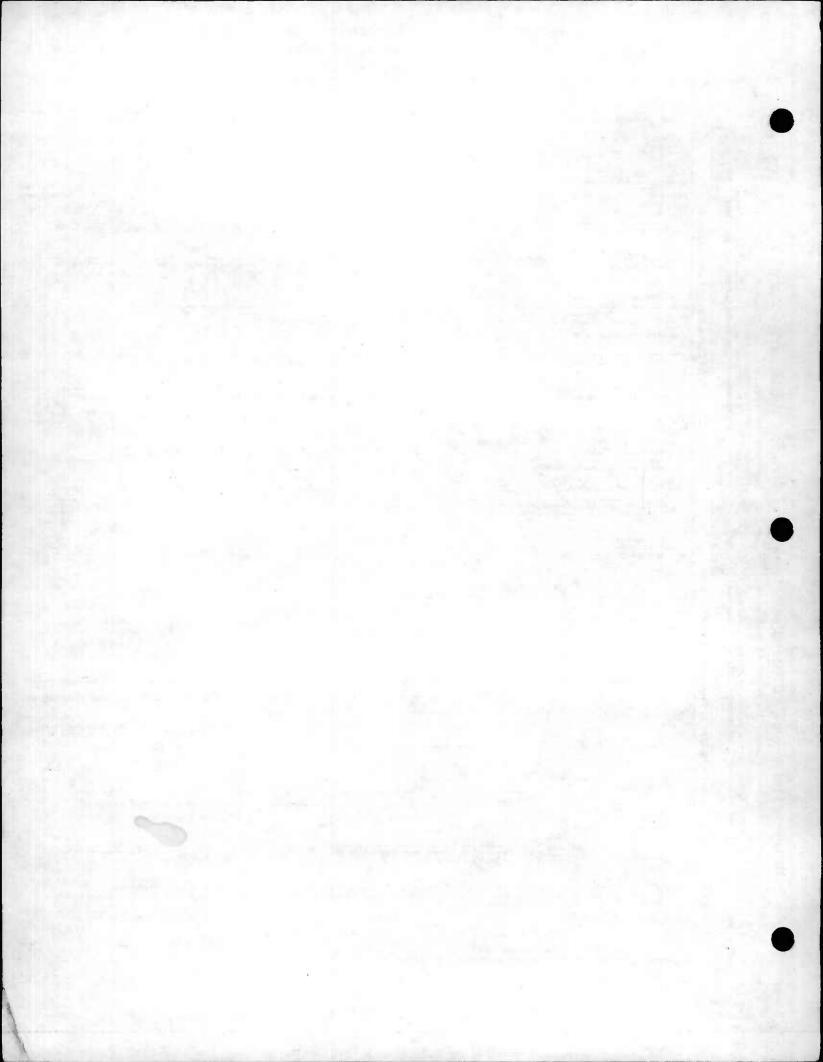
ss of person who completed cause of death (Item 23s) (Type, Print)

9410 Old George town Road, Bethesda, Maryland 20817

State Registrar

3

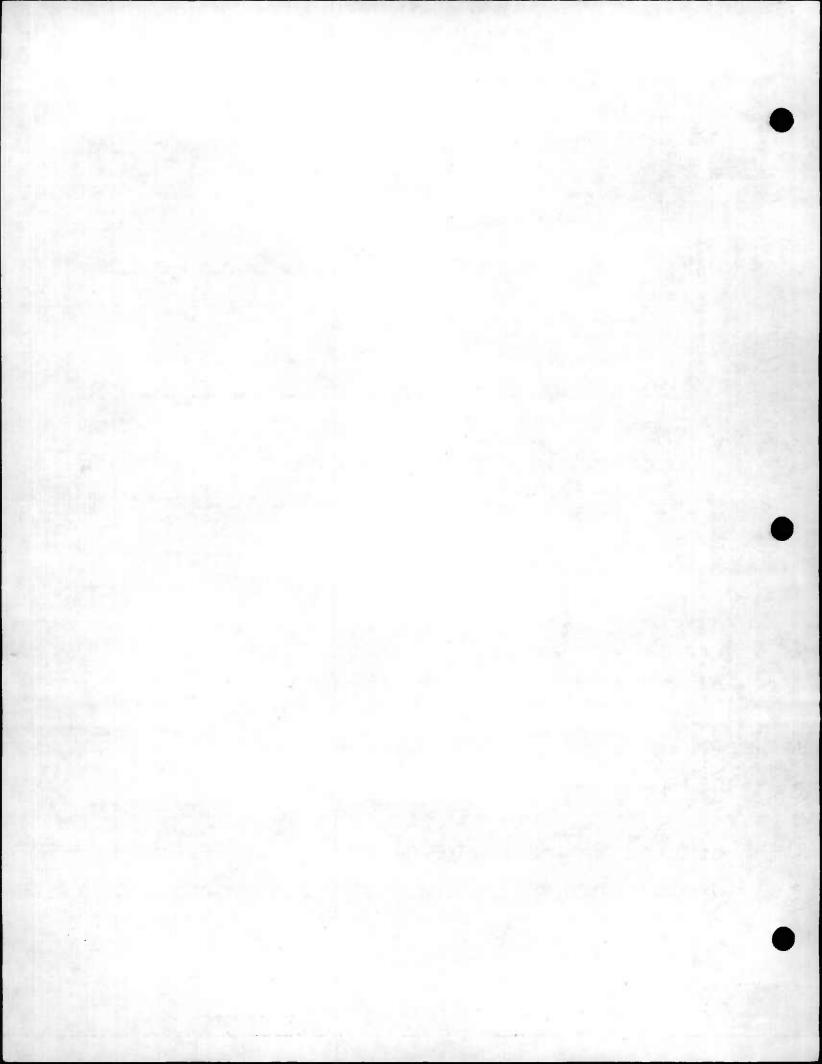
31. Dete fited (Month, Day, Year) MAY 01 2000



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death **Physician** May 2, 4:30 pm 2000 Dorcas Moomaw Stovitz /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Pay, Year) 9. Birthplece (Stete or Foreign Country) Virginia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF Yrs Director 578-01-4838 Usuel Residence of Decedent 10a Stata 10b County 10c City Town or Location 10d. inside City Limits 1 Yes 2 No Directo Rockville 288-1 Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must b 20853 IISA 14102 London Lane Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. it. Pages 1 and 2 should be fied within 72 hours after criment of Health and Montal Hygione.

Trant. If Item 27 is merked other than "natural; or her high y or other traumetic event, the Medical Examinat 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White þ 3 □ Widowed 4 □ Divorced Yeer or Detes Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 17. Fether's Nema (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be Lillie Funkhouser Labon Moomaw 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 4910 29th Road South, Arlington, VA 22206 Alan L. Stovitz/ Son 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 X Burlel 2 ☐ Cremation 3 ☐ Removel from Stete Parklawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 5/5/00 Rockville, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immedieta Cause (Finel disease or condition resulting in deeth) /Medical SEPSIS DAYS Examiner Due to (or es a consequence of): Physician/Medical Examiner sician and burial-trans Sequentielly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or injury that initieted evants rasulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician s the buria Dua to (or as a consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 ☐ Yee 2 No 3 Probably 4 Unknown FIBRILLATION Sompleted b 24b. Were eutopsy tindings available prior to completion of cause of death? 24e. Was en eutopsy FAILURE 1 Yes 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To E 1 Yas 2 No Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28a. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) filled in by # 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 🕒 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date end place, and due to tha causa(s) and mannar as stated. 29a. Cartifiar N (Check only one) 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and menner steted. 29b. Signeture and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) P. Taluras, MD. D 36552 MAY 2000 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) Pankaj Talwar, MD 50 W. Edmonston Dr., #401, Rockville, MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signetura State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Deeth 3. Time of Death Month **Physician** May 2, 4b. City, Town, or Location of Death Jane E. Studer 2000 10:23 am /Medical 4a Fecility Neme (if not institution, give street end number) 4c. County of Death Examiner Suburban Hospital Bethesda If Under 24 Hrs. Montgomery If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) 6 Sax 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Months Deys Hours 10M XDF 37 Yrs. May 25, 1962 578-84-1200 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8206 Garland Avenue Funeral 20912 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White XX Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Landscaper Lawn Care

Physician /Medical

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Nem 27 is marked other
any injury or other traumatic event.

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

rithen "natural", or items 23s or 28s-f show the Wedical Exempler must be nothers at

Examiner

attending physician and for use as the burial-transit should be d page 2

death. after death 6 24 hours To the Hosp within 24 hor To the Fune completaly fi

Certification: To edical

Examiner Physician/Medical by Completed Be

27. Manner of Death

May 2, 2000 10:23 am

Registrar **DHMH 16 Rev 6/95**

10

State

31. Date filed (Month, Dey, Year)

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signeture and title of certifier

Anushiravan Dadgar

MAY 04

3 Suicide

29a. Certifier

5 Pending

investigation

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be determined

28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

13219 Executive Park Terr., Germantown, MD

29c. License number

H51280

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Dey Year)

32. Registrar's Signature

merca

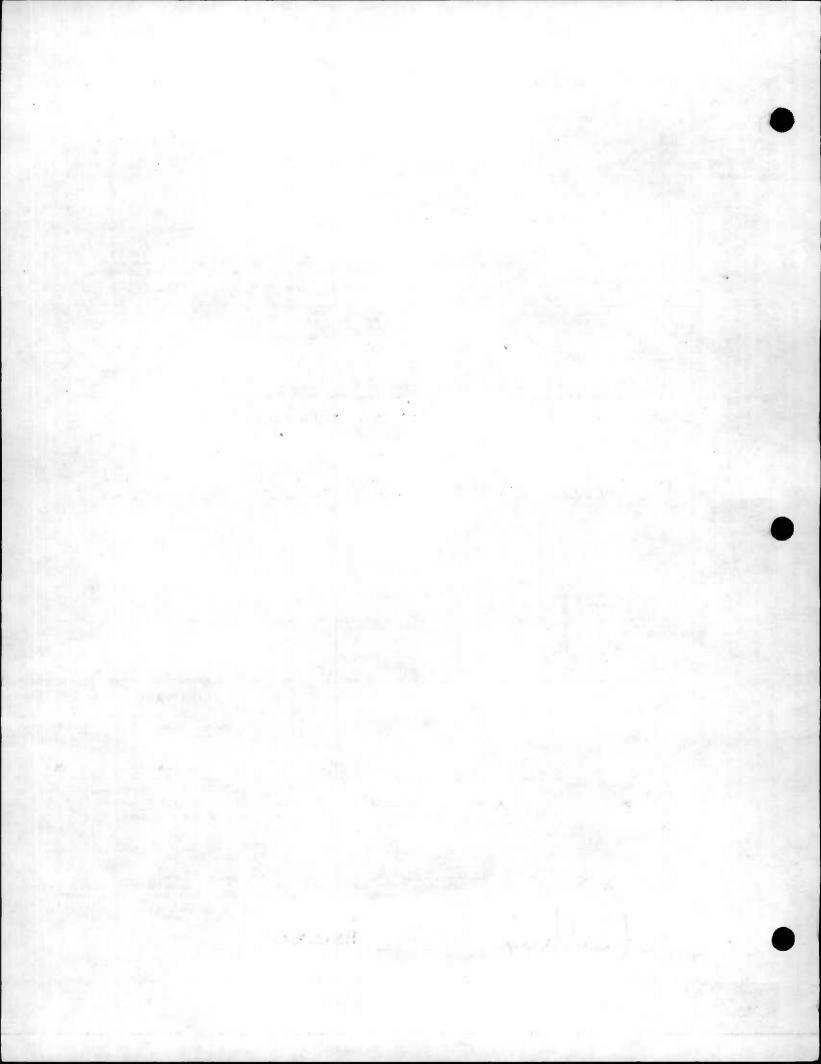
28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

May 3, 2000

20874

29d. Date signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15921

BELLEVIE				Cei	rtificate of	Death		Reg. No.		
1. Decedent's Name (Fi	irst, Middle, Las	st)					2. Date of Do	eath Day	3. Time	of Death
WILLIAM BE	RYAN SO	UDER					May	,	2000 085	68
4a Facility Name (if not	t institution, give	e street and nun	nber)			4b. City, Town, or				
Memorial	Hospit	tal				Easton		Tall	bot	
5. Social Security Numb	per 6. S		7. Age (in yrs.	. last birthday)	If Under 1 Yea Months Days				9. Birthplace (Stat Country)	e or Foreig
214-20-5420	U	M S L L	72	Yrs.	Monaro Sey		OCT. 5		MARYLAND	
Usual Residence of Dec			10. 0	No. Taxana and a						
	b. County		10c. Ci	ity, Town or Lo	cation				10d. Inside	
MARYLAND DO	ORCHEST	ER	H	URLOCK					104	es 2 N
MARYLAND DO	r				10f. Zip Code			10g. Citizen of V	Vhat Country?	
	ANK LAN	DING				21643		USA	A	
11. Marital Status		12. Was Dece Armed For	dent Ever in L	J,S. 13. \	Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N	0- 14. Raci	a - American Indien, k, White, etc.	
	2 Married	1 XYes If Yes, Giv	2 No		1□ Yes 2ŽN		rio i liouri, oto.,	- 34 - 1 - 1 - 1 - 1 - 1		
3 ☐ Widowed 4 ☐	Divorced	Year or Da	ites:		ID 162 SET-140	э эрөспу.		Specity	WHITE	
	Decedent's Ed			16a. Deced	dent's Usual Occi	upation	ndina	16b. Kind of Bu	siness/industry	
Elementary/Secondar		College (1	-4or 5+)	life. I	DO NOT use retir	e during most of wo	Jiking			
15. (Specify of Elementary/Secondar					SUPERVI	SOR		FEDERAL	GOVERNME	1T
17. Father's Name (First	st, Middle, Last)					18. Mother's Na	ame (First, Middle	, Maiden Sumem	10)	
WILLIAM EDO	GAR SOU	DER				NORMA H	AZEL SCA	AGGS		
19a. Informant's Name/	/Relationship (1	Type, Print)		19b. Maitir	ng Address (Stree	et and Number or F	Rurai Route Numi	ber, City or Town,	State, Zip Code)	
D. BRYAN SO	OUDER/SO	ON		904 L	OCUST ST	TREET, CA	MBRIDGE.	MD 2161	3	
20a. Method of Dispositi		24-14-		Place of Dispo	sition (Name of		Date		City or Town, State	
1 Burial 2 Cr.	rametion 3	Removal from S	itate		VETERANS	,	5/3/00	BEIII AU	MARYLAND	
21. Signature of Ednera		-	2.4				1			
1	1	1	1000	ZE	LLER FUI	ress of Fecility NERAL HOM	E, P. O.	BOX 207	7	
/ Xcnc	ucch	7.4	ece	U 10	6 MAIN	STREET, E	AST NEW	MARKET,	MD 21631	
Paul, Enter the di shock, or heart fail	isease, or comp	blications that	used the deal	th. Do not ente	er the mode of dy	ring, such as cardia	c or respiratory	arrest,	Approxin tnterval E	ate
									Onset ar	d Death
Immediate Cause (Fina disease or condition	at	Arte	rioscl	erotic	Cardiova	ascular D	isease		yea	rs
resulting in death)		a	Due to (or as a conseq	mence of):					
			0.0010		, , , , , , , , , , , , , , , , , , , ,					
Sequentially list condition if eny, leading to immedicate the cause of	000	b. ———	Due to (or as a conseq	mence of):					
Sequentially list condition if eny, leading to immediate. Enter Underlying Cause. (Disease or injury)	diate									
Cause (Disease or injury that initiated events		C	Due to (r	or as a conseq	neuce of:					
Cause (Disease or injury that initiated events resulting in death) Last			D00 10 (1	n as a conseq	derice ory.					
		d								
		- Inch						11114		
Part II. Other elgnificant	it conditions co	ontributing to de	ath but not res	sulting in the u	nderlying cause g	given in Pert I.			ntribute to the caud	
	st coro	nary ar	tery b	ypass s	surgery	4 months.	10	Yee 2 No	3 □ Probably 4	Unkn
							04-144-	Maria e de la compansión de la compansió	24b. Were autops	u finalina
							perl	s an autopsy ormed?	aveilable pri	or to
		114							of death?	
							1 🗆	Yes 200	1 ☐ Yes 2	□ No
	to medical					26. Place of De	eath (Check only	one)		
25. Was case referred to examiner?		Hospital: 1 1	patient 2	ER/Outpatien	t 3 DOA	ther: 4 Nursing	Home 5 □ Res	idenca 6 DOth	er (Specify)	
	Dendin-	28a. Date of	t Injury	28b. Time of Injury	28c. Inj	ury at ork?	28d. Describe	how injury occurr	red	
1 Natural 5 2 ☐ Accident	Pending investigation			,		Yes 2 No				
3 ☐ Suicide 6 [Could not be determined	28a. Piece			eet, factory, office	9	28f. Location	(Street and Numb	er or Rurai Route N	umber,
- I HOMIGIGE		DUIIDING	g, etc. (Speci	·y/			City of Te	mi, siate/		
			pest of my kno	wledge, death	occurred at the	time, date and place	a, and due to the	cause(s) and ma	inner as stated.	
27. Manner of Death X Natural 5 2	Certifying Phy	reician: To the		ation and/or inv	vestigation, in my	opinion, death occ	urred at the time	, date and place,	and due to the caus	B(S)
	Certifying Phy Medical Exam	reician: To the la ilner: On the ba and mann	sis of examina er stated.		,					
29a. Certifier 1 (Check only 2	(Medical Exam	Iner: On the ba	sis of examina er stated.			nse number		29d. Date signed	d (Month, Day, Year)
	(Medical Exam	Iner: On the ba	er stated.)	29c. Licer				d (Month, Day, Year)
29b. Signature and title	of certifier	Stous	or stated.),	29c. Licer			29d. Date signed 5/3/00	d (Month, Day, Year)
29a. Certifier (Check only one) 29b. Signature and title	of certifier of person who co	Slows	of death (Iter	n 23a) (Type,	29c. Licer D0680	04	MD 21	5/3/00	d (Month, Day, Yea)
29a. Certifier (Check only one)	of certifier Of certifier of person who ce tout, M	Story completed cause 1. D. 219	of death (Iter	n 23a) (Type,	29c. Licer D0680	04	n, MD 21	5/3/00	d (Month, Day, Year)

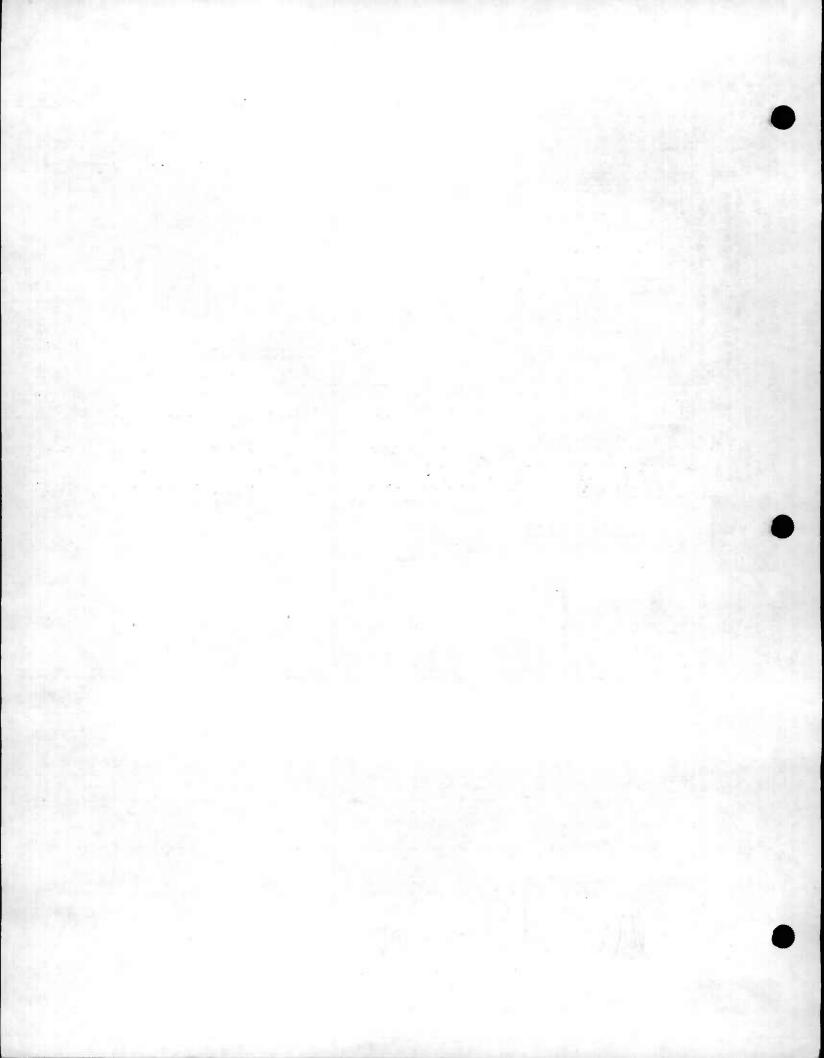
MAY 04 2000 Some B. Spark

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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				Cer	tificate of	Death	R	eg. No.	1 0	360
		ecedent's Name (First, Middle, La	ast)				2. Dete of Dee	th	Vaar	3. Time of Deeth
Physician		Hidetos	hi Tanaka				Month April		Yeer 000	8:25 PM
/Medica Examine	An E	Facility Name (If not institution, given				4b. City, Town, or L		4c. County		0.25 111
Zamine		asey House				Rockvil	10	Montg	omer	N7
Funeral			Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.				lece (Stete or Foreign try)
Director	25	2-42-1237	1⊠M 2□F	66 Yrs.	Months Days	Hours Min.	Oct. 5.		-	pan
		el Residence of Decedent		00			1000. 39	1933	Ja	pan
yland #	10a.	State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
Mer	Ma S	ryland Montgom	erv	Gaithe	ersburg					1 ⊠ Yes 2 □ No
1 28 Th	X	Street and Number		CGIVIII	10f. Zip Code		1	Og. Citizen of W	het Coun	try?
Man Will	2 30	02 Skidmore Blvd	4		2087	77		United	Stat	.00
death	-	Marital Status	12. Wes Decedent Ever in	1 U,S. 13. V		Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No-	14. Raca	- Americ	an Indien,
0 4 5	2	I Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				o Rican, etc.)	Bieck	k, White,	etc.
21215-0020 d within 72 hours after death with the Merylar giene. Is then "natural", or Nema 23e or 28e-f show the Medical Examinar must be notified at	P S	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:	1	☐ Yes 2⊠ No	Specify:		Specify:		ian
15-0020 72 hours after death with the Meryland "natural", or Nerna 23a or 28a-f show redical Exercities must be notified a	Completed	15. Decedent's E	ducation	16e. Deced	ent's Usuel Occu	pation		16b. Kind of Bu		
	9 E	(Specify only highest gradementary/Secondary (0-12)	ade completed) College (1-4or 5+)	life. L	kind of work done OO NOT use retin	during most of wor ed)	king			
A Viger	6	orionally (0-12)	5+	Mi	nister			United N	letho	dist Church
五書書	17. 6	Father's Name (First, Middle, Last)			18. Mother's Nen	ne (First, Middle,	Maiden Sumemi	e)	- 19
ic sent a	P	Nobuta	Tanaka				Tatsuk	o Hi	muro	
permit. Pages 1 and 2 should be filled within Department of Heelih and Menlel Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Menlel		. Informant's Name/Reletionship (19b. Meilin	g Address (Stree	and Number or Ru				Code)
Marita and 2	CI	hieko Tanaka/Wii	Fo	302 81	ei dmoro	Blvd., Ga	itherchy	ra Mar	w1 an	d 20877
Ø = ₹ = #		Method of Disposition		b. Pleca of Dispos	sition (Neme of			20c. Location - (
Baltimore, Maryland femil. Pages 1 and 2 should be file bearment of Heelth and Mentel Hy mportant: If them 27 is marked other in Injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event.		1 ☐ Burial 2 ☑ Cremation 3 ☐			netory or other pla		100 100			
If In It In		4 Donation 5 Other (Special	1	tropoli		atory 4	/29/00 A	Lexandr	1a,	Virginia
Deem Permi	Tall	Signature of Funeral Service Lice	nsee (70 2	. Neme end Addr	ess of Fecility De	Vol Fune:	ral Home	9	
_ 40264		Meden	LULI	Cel 10	East De	eer Park l	Dr., Gai	thersbur		D. 20877
	23a	Part1. Enter the disease, or corr shock, or heart failure. List only	plications that caused the d	eath. Do not ente	or the mode of dy	ing, such as cardiac	or respiratory arr	est,		Approximete Intervel Between
Physician									1	Onset and Death
/Medical	dise	nediete Cause (Final sase or condition	a Metastatic	Colon C	ancer				1	8 months
Examiner		ulting in death)		o (or es e conseq						
n =	e l									
rifficets be assouted ng physician and as the burial-transit	Seq if an	uentially list conditions.	b. Due to	o (or es e conseq	uenca of):					-2-7
Land Bar	if an	uentially list conditions, by, leading to immediate se. Enter Underlying se (Disease or injury								
ortificate be assout ding physician end se as the burial-tran	O mai	initiated events	C. Due to	(or es e consequ	uenca of):					
as the state of	S lesu	Iting in death) Last							i	
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res that the death or signed by the attend doe detached for us	Physician/	II. Other significant conditions of	Antiboting to death but not	esauting in the Uf	radinying cause g	TOTAL				
							101	es ZWNO	J Prot	bably 4 Unknown
v requires that the been signed by it should be detach.	P P						24a. Wes a	n eutopsv	24b. We	ere eutopsy findings
nped uponly	9						perfor		601	aileble prior to mpletion of cause
2 8 8									of	deeth?
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DIVISION OF VITAL THE PROPERTY OF VITAL THE LAW IN 24 hours efter death. The Funeral Director: After this certificate has be pletely filled in by the funeral director, page 28	25. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	examiner? I Yes 2 ∑No Vanner of Death ∏ Natural 5 Pending investigation 3 Suicide 6 Could not be determined Certifier (Check only one) Yes 2 ∑No	28a. Dete of Injury (Month, Dey Year 28a. Piece of Injury - A building, etc. (Spannysician: To the best of my in miner: On the basis of exam	28b. Time of Injury	28c. Inju Wc Wc M 1 [occurred et the t estigation, in my 29c. Licer	ther: 4 Nursing H	th (Check only or order to the Check of the check only or order to the check of	enca 6 StOthe ow injury occurrence treet and Number n, State) euse(s) and mediate and place, e	or (Specify ed er or Rure nner es stand due to (Month,	I Route Number, seted. the couse(s) Dey, Year)
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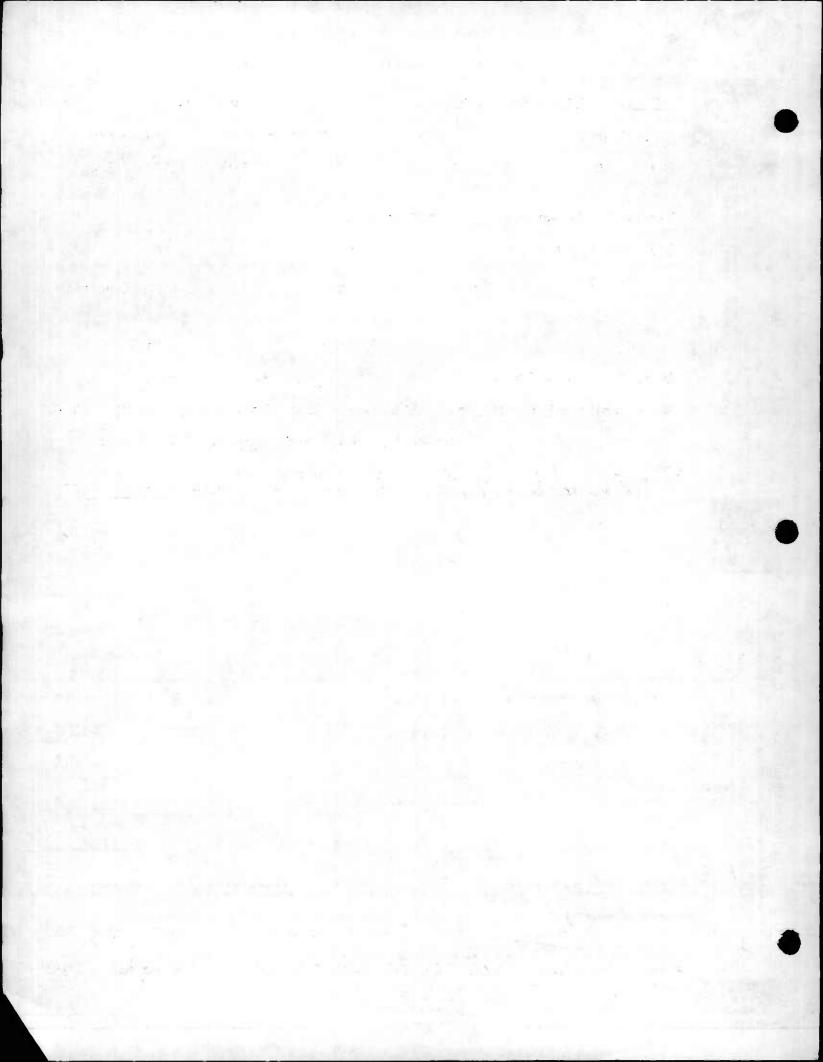
State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #1 PER PHY G783 5-24-00 5-24-00 entiticate of Death 1. Decedent's Name (First, Middle, Last) MEHDI TABIBZADEH TEHRANI 2. Date of Death 3. Time of Death April 24, 2000 Year **Physician** 7:00am Medhi Tabibzadeh Tehrani /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gaithersburg 12516 Seurat Lane Montgomery Hours Min. 8. Data of Birth (Month, Pay, Year) July 19, 1928 if Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthday) 9. Birthplaca (Stete or Foreign Country) **Funeral** 1₩ 2□ F Months Davs 309-04-8501 Director Usual Residence of Decedant 10a. State s 23e or 28a-f show want be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f Zin Code 10g. Citizan of What Country? items 23e 12516 Seurat Lane 20878 Iran Funerai 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0020 naturel', or 1 Yes 2 No Specify: specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hs. Department of Health and Mental Hygiene. Important if item 27 is marked other than "naturany injury or other tranmatic event, its Medical pages. Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Sacondary (0-12) College (1-4or 5+) Officer 0 6 Military 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumeme) Be Abbas Tabibzadeh Tehrani Khanom Bozorg Aghajani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) Saeid Tabibzadeh Tehrani/Son 12516 Seurat Lane Gaithersburg, Maryland 20878 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park Falls Church, Virginia 4/25/00 27 Signature of Funeral Service Lice 22. Name end Address of Facility
National Funeral Home (moto 7482 Lee Hwy Falls Church, Virginia 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List dry one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) STROKE INSTANT Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificete be axecuted the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last for use as Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? MELLITUS DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Ware autopsy findings aveileble prior to completion of cause of daath? Completed CARDIAC ARRTHYMIA 24a. Was an autopsy performed? Aftar this cartificate has STROKE 1 Yas 2 No 1 Yes 21 No Attending Physicien: 25. Was case raferred to medical examinar? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Mannar of Daath 28a. Date of Injury (Month, Dey Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be datermined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, death occurred at the time, dete and placa, and dua to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, date and placa, and dua to the cause(s). Medicai 29a. Certifier r: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, date and placa, and dua to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 28656 3 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) SECOND AVE. #404B, S. SPRING MD 20910 YASSI 8609 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State

Registrar

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 1 . State of Maryland / Department of Health and Mental Hygiene Amend #26, 5/3/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 25, Etta Whitmore Tinner April 2000 1:17pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Group Residence Home | fl Under 1 Year Rose's Place Inc. Upper Marlboro
If Under 24 Hrs. 8. Date of Birth Prince George's 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 224-68-2336 Director 99 Dec. 18,1900 VA Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow must be notified at 1 ☐ Yes 2125No Director VA Fairfax Falls Church 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Peges 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 2 any liqury or other traumetic avant, the Medical Exertine must be a page. 7308 Paekwood Ct. Apt#202 22042 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Biack, White, etc. 1 ☐ Nevar Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Edward Whitmore Mamie Gibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 1104 46th St. S.E. Washington, DC. 20019 Mildred T. Teak- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State PEBurial 2 ☐ Cremation 3 ☐ Removal from State Second Bapt. Church Cemetery 4 □ Donation 5 □ Other (Specify) Falls Church, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joynes Funeral Home P.O. Box 3633 Warrenton, VA. 22186 m. leen Approximate Interval Batween Onset and Deeth Part 1. Enter the disease, or complications that caused that eth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be assecuted attending physicien and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Que to (or as a consequença of): P.O. Box 68760, Heav Physician/Medical Due to (or es à consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be detach 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attanding Physician: after death. Director: After this certifice director, 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home - 5 The Studence 6 Nother (Specify Toup home 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manper of Death 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) á 4 ☐ Homicide 24 hours after Funeral Dira letely filled in b Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only 2 Medical E ner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) 00

Registrar DHMH 16 Rev 6/95

State

30. Name and addless of person who compl

31. Date filed (Month, Day,

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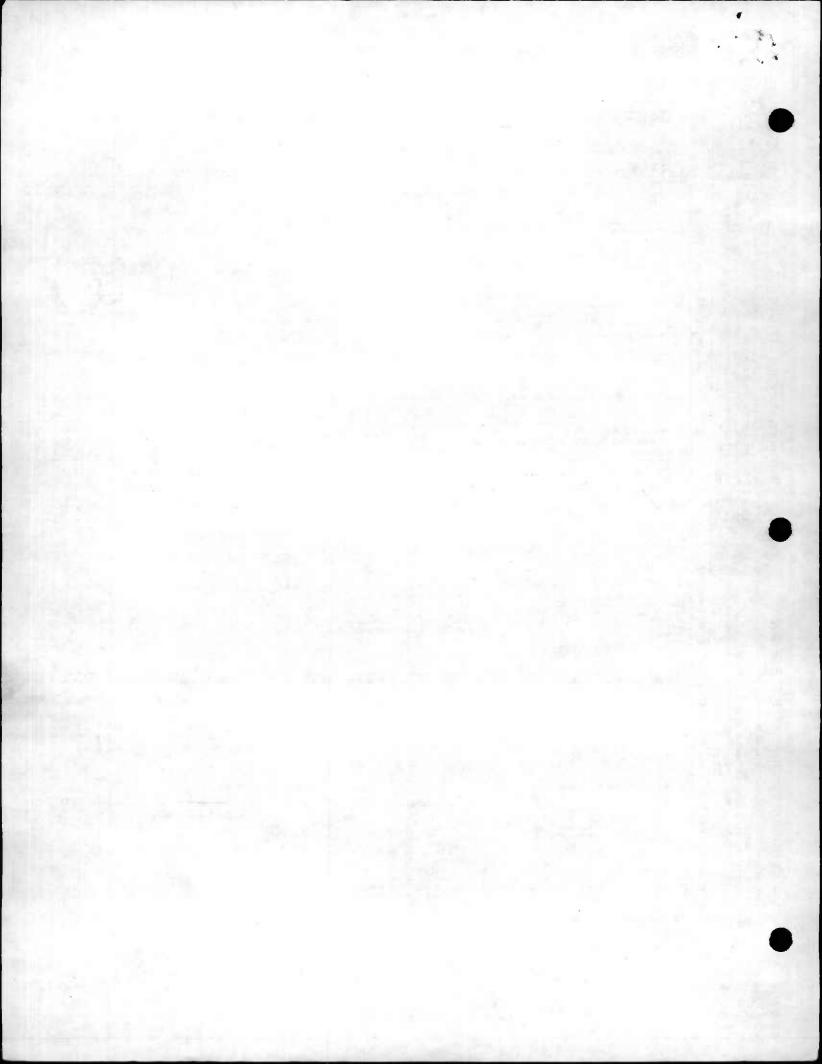
03

2000

16th

d cause of death (Item 23a) (Type, Print), 2815

32. Pegistrer's Signature



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State of Maryland / Department of Health and Mental Hygiene

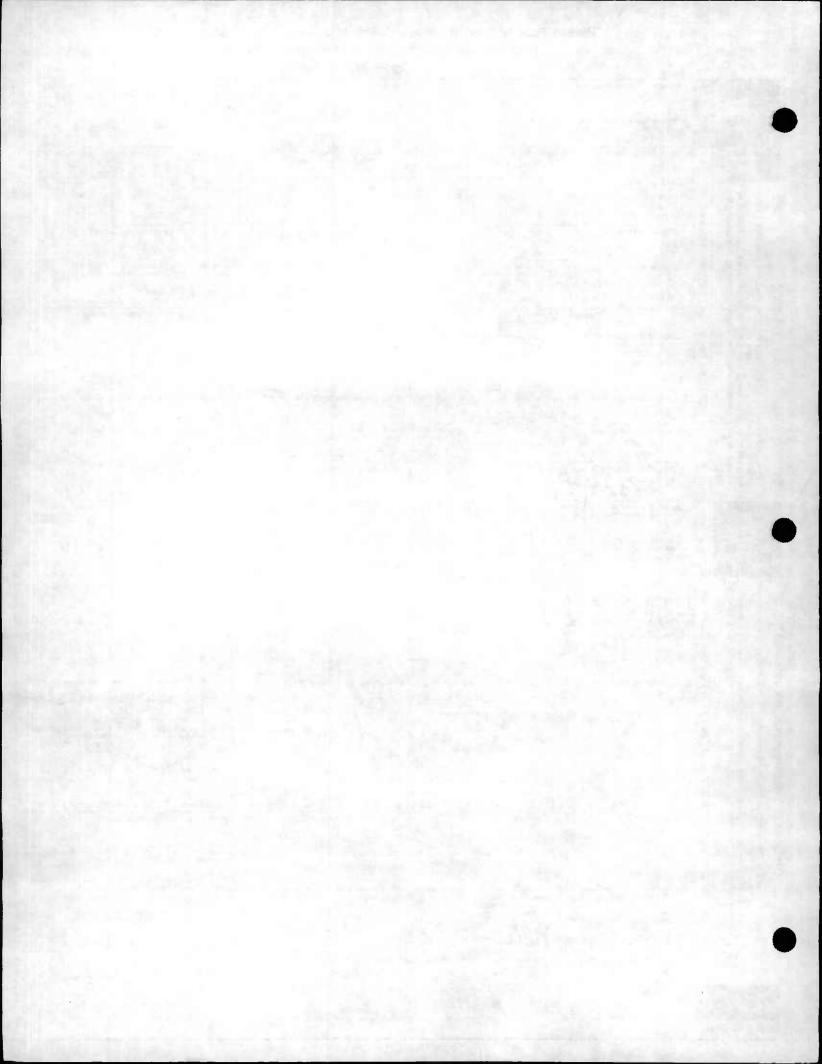
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** April 28, 2000 LaDosca Umbarger 5:40 am /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY Months Deys If Undar 24 Hrs. Hours | Min. Birthpleca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 DF Director 567-36-1054 70 April 1, 1930 N. Carolina Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23s or 28s-f short 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Montgomery Village the Medical Examiner must be notif 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9716 Digging Road 20886 United States Funeral 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🛣 No tf Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify. by Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene, other than College (1-4or 5+) 5+ Elementery/Secondery (0-12) Teacher Elementary Education permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important if Hear 27 is marked other it
any Injury or other traumatic event, III
ottos. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Nama (First, Middla, Last) Be John Kenneth Yeatman Pearl LaDosca Hodges 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Neme/Reletionship (Type, Print) J. Kenneth Umbarger, 9019 Centerway Road, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition May 1 ABuriat 2 ☐ Cremetion 3 ☐ Removatorm Stete Gate of Heaven Cemetery 2000 4 Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Sarvice License 22. Nama and Addrass of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part# Entar tha disaass, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heer feilure. List only one ceusa on each line. Approximate tntervet Between Onset and Deeth **Physician** /Medical Immediate Causa (Final 30 hours disaesa or condition resulting in death) Examiner ASTATI Physician/Medical Examiner ate hes been signed by the attending physician and pege 2 should be deteched for use es the bunel-transit The law requires that the deeth certificate be executed Sequentielly tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? PlennAl 1 Yes 2 No 3 Probably 4 Unknown þ AVIAN VEIN THR 24a. Wes an eutopsy performed? 24b. Were autopsy findings availebla prior to completion of causa of death? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No After this certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical exeminer? Certification: To Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 500 1 DInpatient 2 ER/Outpatient 3□ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1' DNaturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) menner stated. edical 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Ittle of certifier 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernwaad Road 1N, MD 31. Date filed (Month, Day, Year) 32. Registrer's Signetura State 2000

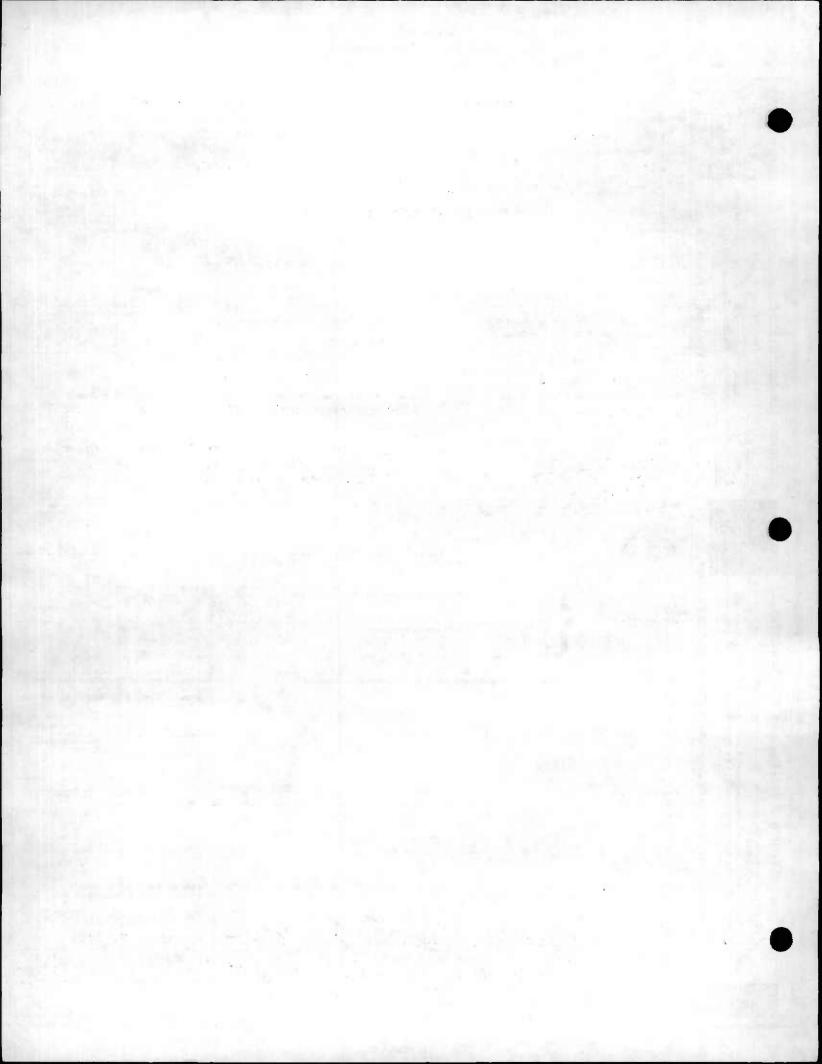
DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierre 1 5 0 2 9

	Certificate of Death	R	eg. No.	0 372
Physicia	1. Decedent's Neme (First, Middle, Last) Ellen Lynard Vouzikas	2. Dete of Dear Month	Dey Year	3. Time of Death
/Medica	do Facility Name (Manaking day appearance and appearance)	April r Location of Death	28 2000 4c. County of De	11:20AM
Examine	11109 Easecrest Drive Silver S		Montgom	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr S78-30-8468 1 Months Days Hours Mile	rs. 8. Date of Birth	9. 8 1905 W.	irthplace (State or Foreign Country) shington, DC
Director	Usual Residence of Decedent	HOV. 2,	1303 Wa	SHILING LOH, DC
yland	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mar Line	Maryland Montgomery Silver Spring			1 ☐ Yes 2 ☐ No
h with the	Maryland Montgomery Silver Spring 10e. Street and Number 11109 Easecrest Drive 20902 11. Merital Stetus 1 Never Merried	1	0g. Citizen of What 0	Country?
within 72 hours after death with the Maryland ene. Than "natural", or items 23s or 28s-f show the Medical Examinal must be notified at	a 3 □XWidowed 4 □ Divorced Yeer or Detes:	(Specify Yes or No- arto Rican, etc.)	Specify:	nerican Indian, nite, etc. Thite
n 72 hours "natural",	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	ndina	16b. Kind of Busines	s/Industry
ithin 7	Elementery/Secondery (0-12) College (1-4or 5+)	Orking	0 11	
	8 Homemaker		Own Hon	ie
tal H	17. Fether's Neme (First, Middle, Last)	ame (First, Middle, I	Maiden Sumeme)	
Mer		la Dounis		
permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exercitions.	19e. Informent's Neme/Reletionship (Type, Print) Zoe V. DeFonzo / Daughter 19b. Meiling Address (Street end Number or H 11109 Easecrest Drive			
T See 1	20a. Method of Disposition 1 □ XBurial 2 □ Cremetion 3 □ Removel from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other place)	155	20c. Location - City	
tmen tant:			uitland,	•
Deparition of the part of the	21. Signeture of Funeral Securco (icunsor) 22. Name end Address of Fecility H 11800 New Hampshi Silver Spring, Ma	re Avenue		al nome
	23. Part. Enter the bounds of complication that caused the death. Do not enter the mode of dying, such as cardisance, or ream failure. List only one sause on each line.			Approximate Intervel Between
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)		139	Onset and Death
P # .	Due to (or esta consequence of):			
tificate be asscuted to physician and as the bunial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest b. Due to (or as a consequence of): c. Due to (or es a consequence of):			
÷ 0 0				
death cert e attendin	Death Other desident and the second s	anh Dista		i de the sever of death?
ires that the death cer signed by the attendir d be datached for use	d Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		es 2 No 3	rte to the cause of death? Probably 4© Unknown
bed .		-		
he law requires e has been sign age 2 should be		24a. Wes a perform		Were eutopsy lindings available prior to completion of cause of deeth?
The law ate has page 2		1 Y	es 2√√ No	1 Yes 2 No
ician: The certificate rector, pag	25. Wes case referred to medical 26. Place of D	eeth (Check only or		
Physicien: This certificateral director, pa	Hospital:		ence 6 Other (S	oecify)
Attending Physic death.		28d. Describe h	ow injury occurred	
2442	27. Menner of Deeth 1 XXNatural 2 Accident 3 Sulcide 4 Homicide 28e. Dete of Injury (Month, Day Year) 28e. Dete of Injury 4 Sec. Injury at Nork? 1 Yes 2 No 28e. Plece of Injury 4 Nork? 28e. Plece of Injury 4 Nork? 28e. Plece of Injury 5 Pending 28e. Plece of Injury 6 Nork? 1 Yes 2 No 28e. Plece of Injury 6 Nork? 1 Yes 2 Nork? 28e. Plece of Injury 7 Nork? 28e. Plece of Injury 8 Nork? 1 Yes 2 Nork? 28e. Plece of Injury 9 Nork?	281. Location (S City or Town	treet end Number or n, Stete)	Rural Route Number,
	29e. Centifier (Check only Check only (Check only Check only	ce, end due to the c curred et the time, d	ause(s) end menner ate end plece, end d	as steled. ue to the cause(s)
within To the compl	29b. Signature and title of certifier 29c. License number	2	9d. Dete signed (Mo	onth, Dey, Year)
	- SIMPRICE FRANCE DOXX	21,7	April 28	2000
Q	30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)	DeP	eltsvi	
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature			120705
Registra	MAY 02 2000 Serve G. South			

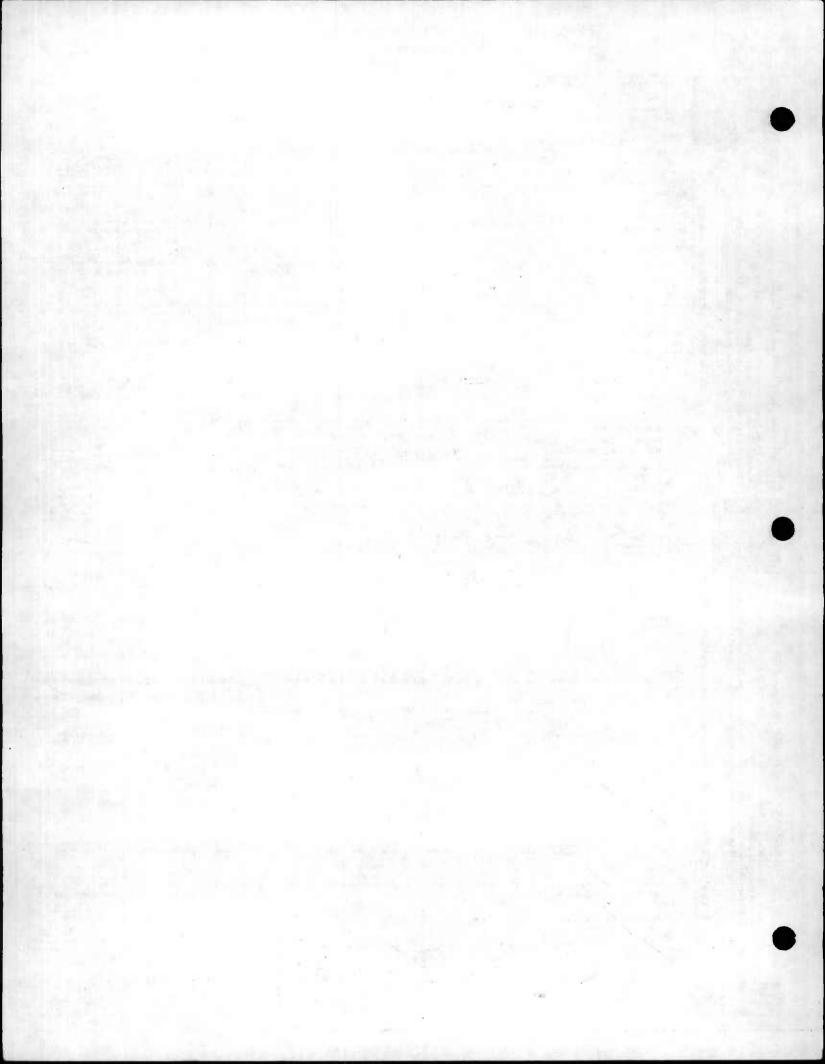


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State of Maryland / Department of Health and Mental Hygiene

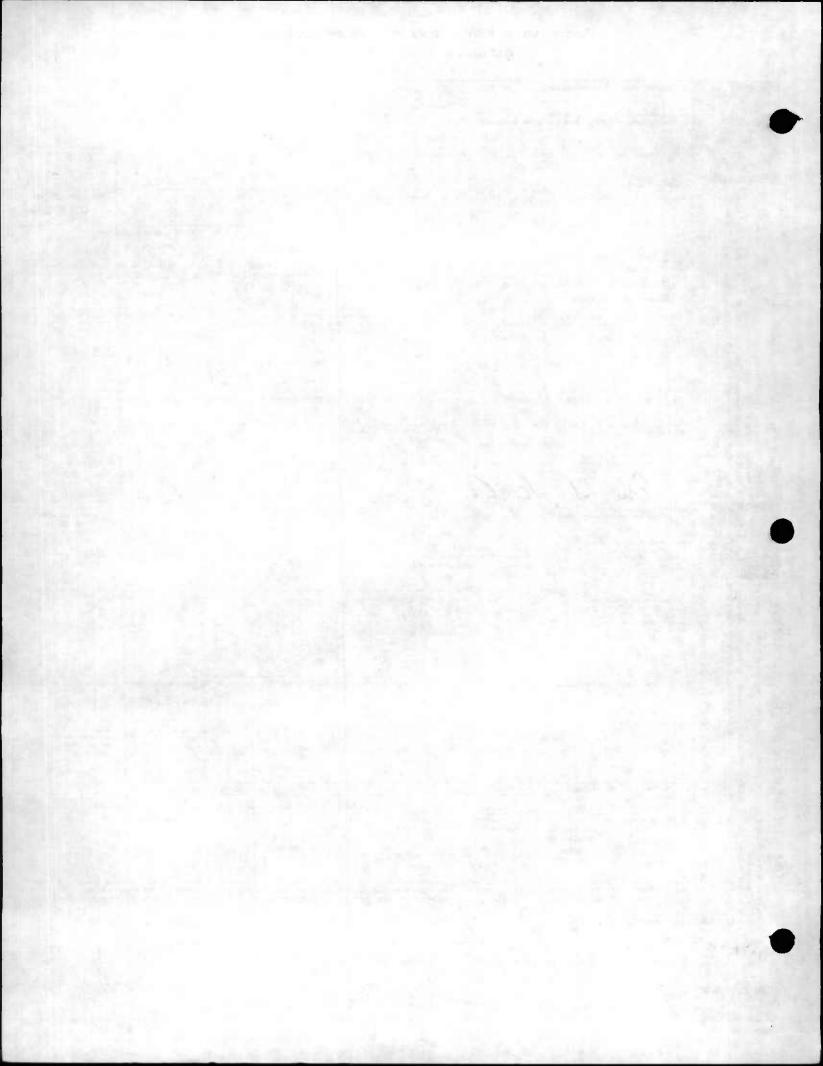
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	1		3	1

	Certificate of D	eath	Reg. No.	10300
Observation	Decedent's Nama (First, Middle, Last)		Data of Death Month Dey	3. Time of Deeth
Physician /Medical	Julia Cecelia White			2000 2:55 AM
Examiner	4a Facility Neme (If not institution, give street and number) 4b.	. City, Town, or Location	on of Death 4c. Coun	ty of Death
		aithersbur		tgomery
Funeral	Months Days	Hours Min. (Date of Birth Month, Day, Year)	Birthplace (Steta or Fore Country)
Director	Usual Residence of Decedent	Fe	b. 15, 1919	New York
ž ==	10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Lim
4 P	Maryland Montgomery Rockville			1 □ Yas 2 🔯
or 28a-f a be notified Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Country?
340	612 Goldsborough Drive 20850		United	l States
al, or terms 23a or 28a-f ahow Examination must be notified at by Funeral Director	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hisps If Yas, specify Cuben,			ace - Amarican Indian,
프로 I	1 Never Married 2 Married 1 Yes 2 No	Specify:		ack, White, etc.
"natural", or	35 Widowed 4 □ Divorced Year or Datas:	Specify.	Speci	White
t, the Medical	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired)	ion ring most of working	16b. Kind of I	Business/Industry
	Elementary/Secondary (0-12) College (1-4or 5+)			
	11 Administrative			al Government
8			st, Middle, Maiden Suma 	
To affe	James Lynch			ensen
Important: if item 27 le marked od eny injury or other treumatic evel poce. To Be	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street an	nd Number or Rural Ro	uta Number, City or Town	n, Steta, Zip Code)
E 4 10	Don White/Son 14 Wayridge Cou 20a. Method of Disposition 20b. Place of Disposition (Nama of			ge, MD. 20886 City or Town, Steta
= 9	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State			
fury	4□Donation 5□Other (Specify) Metropolitan Crema		/00 Alexan	dria, Virgini
Pod C	21. Signature of Funeral Service Licensee	of Facility DeVo	1 Funeral H	ome
= • a	Della 10 East Deer	Park Dr.	Gaithersbu	irg, MD. 20877
sician edical miner	23a. Part 1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, shock, or heart leiture. List only one cause on each line. Immediata Cause (Finel disease or condition resulting in death)	Such as Cardiac of fas	spiratory ariast,	Approximata Interval Between Onset and Death
in and dal-transit Examiner	b. diabetic Dephrop	athy	3-12	years
ing physicis as the bur Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): C. Dua to (or as a consequence of):	SJ		years
ed for us	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23b. Did tobacco use c	ontributa to the cause of d
ed by the detach			1 Yes 2 No	3 Probably 4 Unk
2 should be pleted by			24a. Was an autopsy performed?	24b. Were autopsy lindin available prior to completion of causa of death?
Page Poge			1 Yas 2 No	1 ☐ Yas 2 ☐ No
irector, par irector, par o Be Co	25. Was case referred termedical	26. Place of Deeth (Cl	neck only ona)	
90	axaminer? 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:		5 ☐ Rasidenca 6 ☐ O	thar (Specify)
	27. Manger of Death 1 Netural 5 Pending (Month, Day Year) 2 Accident 28b. Time of Injury Work? Month, Day Year) M 28c. Injury a Work?		Describe how injury occi	
el Director: After tiled in by the funeral Certification:	3 ☐ Suicide 4 ☐ Hornicide 6 ☐ Could not be detarmined 28a. Place of Injury · At horna, farm, streel, factory, office building, atc. (Specify)		Location (Street and Nun City or Town, Stata)	nber or Rural Routa Number,
the Funer splately fill delical	29a. Certifier (Check only 2 Section Check only Ch	, date end place, and onion, deeth occurred a	t the time, date end place	a, end due to the cause(s)
To the	29c. Licensa r	number	29d. Data sign	ned (Month, Day, Year)
10	10 John 201	148	Ma.	1 4,200
(•	30. Nama and address of person who completed cause of death (Item 23a) Ofpe, Print)	Steven Do	Mnsky, M.D.	J
State	31. Data filed (Month, Day, Year) 32. Segistrar's Signatura	1	7	
Registrar	MAY 05 2000 Jenera G. Sparks			



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

						Certifica	ate of			Reg. No.		201
	Physician	1. Decedent's Name (First, Mi	ddle, Last)		MIN				2. Dete of De Month	eth Day	Year 3	3. Time of Death
9	/Medical	Pauline J. Wa				_			May 3,	2000		12:45 pm
	Examiner	4a Facility Name (If not institu		number)				4b. City, Town, or L	ocation of Death	4c. County	of Death	
_		2718 Weller R 5. Social Security Number	oad 6. Sex	7. Age (In y	rs last hirth	nday) If Unc	der 1 Year	Wheaton If Under 24 Hrs.	8 Dete of Bird	Montg		e (State or Foreign
	Funeral Director	166-18-2151 Usual Residence of Decedent	1□ M 2ŽXF			Month			Jun 29	y, Year) 1920 F	Country)	
	pund Bu	10a. Stata 10b. Cou	nty	10c.	City, Town	or Location						Inside City Limits
	Maryla and show iffed at	Maryland Mont	gomery	Who	eaton							1 ☐ Yas 2 No
	vith the Ma t or 28e-f a be notified Directo	10e. Street and Number				10f. 2	Zip Code			10g. Citizen of W	hat Country?	?
	after death with the Maryland or Issue 23s or 28s-1 show uniter must be notified at / Funeral Director	2718 Weller R					906			USA		
		11. Marital Status		ecedent Ever in Forces?		13. Was Dec	pecify Cub	Hispanic Origin? (Sp ben, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Black	- American I k, White, etc.	Indian,
020	within 72 hours alter one. than "natural", or its he Medical Examins empleted by Fu	1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divord	larried 1 X Yes,	Forces? s 2 □ No Give WW I Dates:	II	1□ Yes	2 No	Specify:		Specify:	White	
21215-0020	"natural", or reficel Exam; leted by F		lent's Education		16a. I	Decedant's Us	sual Occu	pation	,	16b. Kind of Bu	siness/Indust	try
215	and within 72 ho typiene. Ner than "naturn It, the Medical.] Completed	(Specify only hig Elementary/Secondary (0-1)	thest grade complete College	d) (1-4or 5+)		life. DO NOT	use ratire	during most of worked)	ang			
CA	DEST O		2		Ho	memake	r			Own Home		
and	B MARK	17. Father's Name (First, Midd	lie, Last)					18. Mother's Nam			9)	
Maryland	Monta de Menta	Joseph Seiden 19a. Informant's Name/Aelati			101	S. S. o Dinner Andrews	on Chan	Theresa			Ctata 7in Ca	nda)
Ma	d 2 s th an 7 is e			1 1			35	t and Number or Rui			State, ZIP CO	oe)
	Health He	Murray Mike W 20a. Mathod of Disposition	aiker/ Hus	spand 20t	. Place of	Disposition (A	vame of	Road, Whea	Date Date	20906 20c. Location - 0	City or Town,	, State
Baltimore,	Pages minimitally my or of	1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		m State M		olitan			5/4/00	Alexand	ria V	Δ
alti	pointle. Pages 1 and Department of Health Important: If New 27 any Injury or other tr	21. Signeture of Funeral Serv		,		22. Name	and Addr	ess of Facility				
œ	Page 18	Vani V	1. Scan	lo				. Collins				MD 20901
		23a. Part1. Entar the disease shock, or haart failure.	or complications the	t caused the de	eath. Do no	ot enter the m	oda of dy	ing, such as cardiac	or respiretory e	rrest,	Ap	oproximate tarval Batween
	Physician	arious, or mant randio.	ist only one causa of	Toacit iiito.								nsat and Death
	/Medical Examiner	Immediata Cause (Final disease or condition	. Adei	nocarci	noma	of Unk	nown	Origin			mo	nths
E		resulting In death)				onsequance o						
	ficete be executed physician and stree buriel-trensit edical Examiner		b								i	
,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit eted by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to	o (or as e co	onsequenca o	of):					
68760,	e be solcial e bun	that initiated events	C	Due to	(nr as a cr	onsequence o	f)·					
68	Medi	resulting in death) Last		Due to	(0) 43 4 01	anaequence o	.,.					
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0.	ires that the death cer signed by the attendir d be detached for use d by Physician/N	Part II. Other significant cond	itions contributing to	death but not i	resulting In	the underlying	g cause g	iven in Part I.	23b. Dld	tobacco use con	tribute to th	e cause of death?
<u>q</u>	d by detach	Hypertension							10	Yes 20 No	3 Probab	oly 4 Unknown
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o	r Phy eral d	27. Manner of Death	28a. Da	te of Injury		me of	28c. Inju			how injury occurr		
O	Attending in death. Sector: After by the fune life ation	1 Natural 5 Per 2 Accident inve	ding (M)	onin, Day rear	, in	jury M		Yes 2□No				
			old not be 28e. Pla	ica of Injury - A	t home, fan	m, street, fact	ory, office		28f. Location (City or To	Street and Number	er or Rural Re	oute Number,
٥	is after a led in b											
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff		ying Physician: To t al Examiner: On the and m									
	withir To th comp	29b. Signature and title of cert	ifield /	197	1	1	29c. Licen	se number		29d. Date signed	Month, Day	y, Year)
	70 - VA	LALI	Uxa	1			D 36	046	ı	May 3, 2	000	
-	10)	30. Name and address of pers	on who completed ca	se of deeth (I	tem 23a) (1	Type, Print)						
	1250	John J. Merend	ino, MD	4701 Ra	ndolp	h Road	#21	6. Rockvi	lle, MD	20852		
	State Registrar	31. Dayle filed (Month, Day, Ye	4 2000	. Degistrer's Signature	gnature	9. 14	sak					



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ian ical	Decedent's Name (First, Mide Thomas John W									2. Dete of Do Month APRIL	eath Day	Year 000	3. Tima of Death 20:35 PM
ner	4e Fecility Neme (If not instituti		et end nun	nber)			4	b. City, Tov	wn, or Lo	cation of Deel	th 4c. Cou	nty of Deet	h
	14208 ARCTIC	AVENUE	Ξ					ROCKVI			MON	VTGOMI	
	5. Social Security Number	6. Sex		7. Age (In yrs.	A CONTRACTOR	If Under 1 'Months D	Yeer Days	If Under a	24 Hrs. Min,	8. Date of Bi (Month, D	irth	9. Birt	hplece (State or Foreign untry)
	216-74-4602 Usuel Residence of Decedent	1 <u>√</u> M	2U F	38	Yrs.					OCt.18	8,1961		yĺand
	10a. Stete 10b. Count	у	155	10c. Cit	ly, Town or Lo	ocation							10d. Inside City Limits
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ruisciai Dir	10e. Street and Number					10f. Zip Co					10g. Citizen		untry?
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	11. Meritef Stetus 1 ☑ Never Married 2 ☐ Me 3 ☐ Widowed 4 ☐ Divorce	orried 1	rves Dece Armed Fo I ☐ Yes If Yes, Giv Yeer or De	2 ☑ No e		Wes Deceden If Yes, specify 1 ☐ Yes 2 🖔		Specify:	gin r (Spo , Puerto	Rican, etc.)		Bleck, White	e, etc.
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	(Specify only high Elementery/Secondery (0-12)		m <i>pleted)</i> College (1	-4or 5+)	(Give	kind of work of DO NOT use	done d	uring most)	of work	ing			
	12		_ sgo (1	3.0.,	Insta	aller					Carpe	t	
	17. Fether's Neme (First, Middle	, Last)						18. Mothe	r's Neme	e (First, Middle	e, Maiden Sun	ieme)	
	William Whi							Mel	va J	. DiGi	rolamo		
	19e. fnforment's Neme/Reletion	nship (Type, F	Print)	mother)	19b. Meili	ng Address (S	Street	and Numbe	r or Run	al Route Numi	ber, City or To	wn, State, 2	Zip Code)
	Doris Melva Di	Girola	imo		14208	Arcti	C	Avenu	e R		le, Mary		
	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (oval from S		Mark	sition (Neme metory or other S Epis	or plec	e) pal		Dete			Town, Stete
					L.CI	necerv			.0	5/01/0	OSilver	Spri	ng Maryland
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State Registrar

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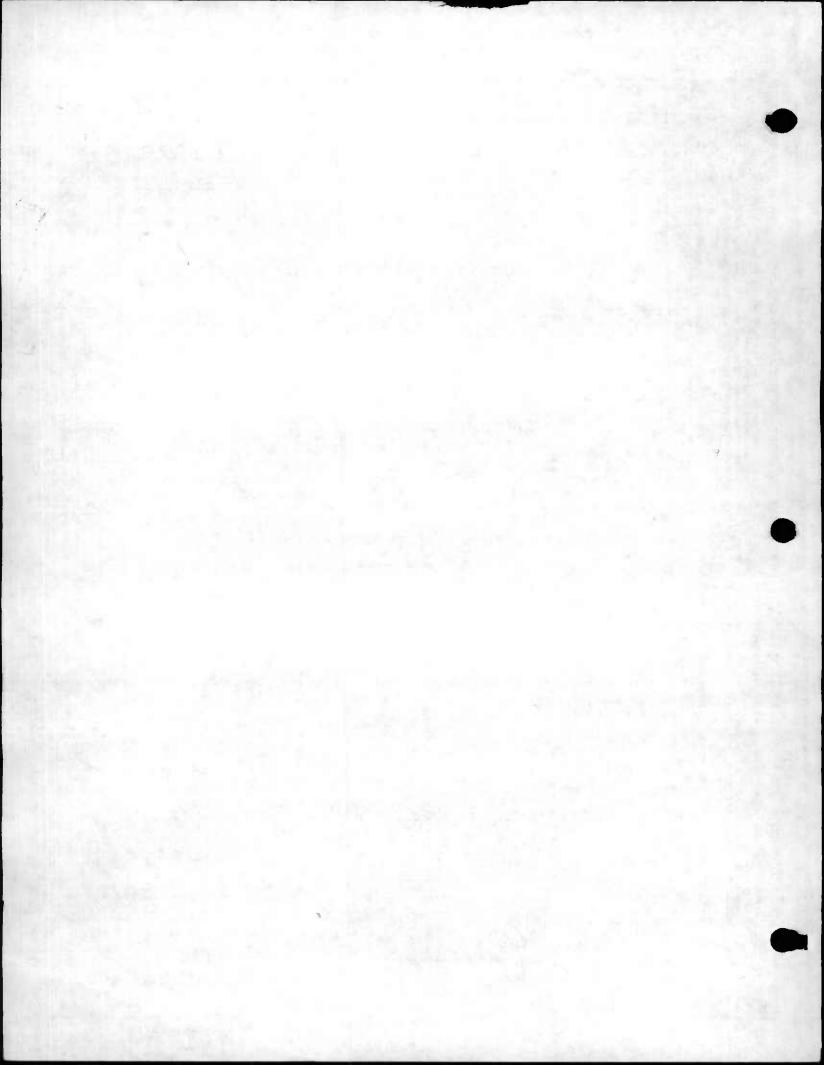
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

OCME

29d. Date signed (Month, Day, Year) APRIL 28, 2000

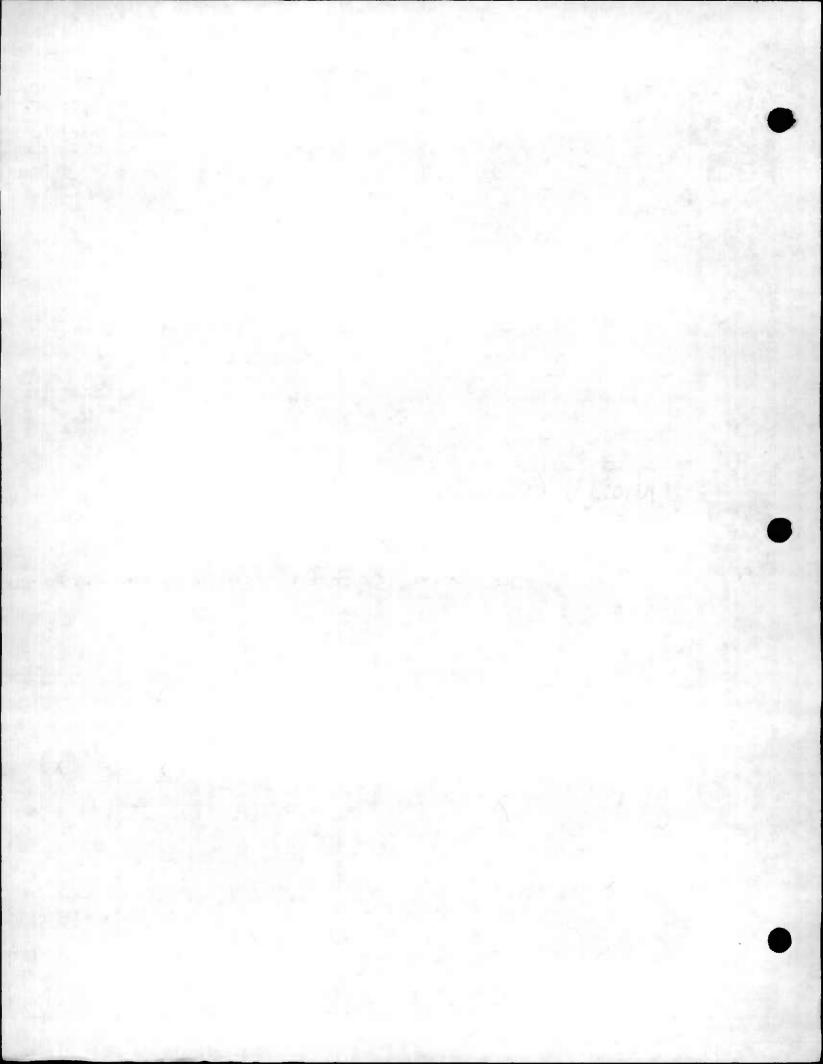


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Year Month Physician Wilma Wingfield 3:00P. 2000 May ./Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** Days Hours Months 1□ M 20 F 577-26-4438 Yrs. 78 Director Dec. 9, 1921 West Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at Yes 2□ No Maryland | Prince George's Greenbelt Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11G Ridge Road 20770 United States Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11. Meritel Stetus 72 hours efter 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry a filed within 7 il Hygiene. other than "n National Geographic Elementery/Secondery (0-12) 12 College (1-4or 5+) Clerical Society permit. Peges 1 and 2 should be flik Department of Heelth end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Y. Hardy McCray May Louise Roby 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Marietta Hartman (sister) P.O. Box 124 Kimberly, West Virginia 25118 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e, Method of Disposition Dete 20c. Location - City or Town, Stete 1 Surial 2 Cremetion 3 Removel from State St. Johns Episcopal Church Cemetery 5/5/00 Beltsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetore of Funeral Service Licent 22. Name and Address of Fecility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Hypoten Sion
Due to (or es a consequence ot): Immediete Ceuse (Finel 1240 urs diseese or condition resulting in deeth) Examiner Examiner gastrointestinal Dieeding physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Box 68760. 90 Physician/Medical Due to (or es e consequence of) as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? P.O. Thrombory topenia 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings evellable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 2 No certificate 25. Was case referred to medical examiner? Be 26. Piace of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 5 To the Hospital or Attanding Phywithin 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral 28b. Time of Injury 28c. Injury et Work? 27 Menner of Death 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Sfreef end Number or Rural Roufe Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title pl-certifier Stavite 000 May 3, 2000 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) David S. Granite, M.D. 115 Centerway Greenbelt, Maryland 20770 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registra MAY 04 2000

DHMH 16 Rev 6/95



29c. Licansa number

GREGORIO M. BELLOSO, M.P.: 5302 CHINABERRY DR .; SALISBURY MD 21801

29d. Date signed (Month, Dey, Year)

10

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(Check only one)

31. Deta filed (Month, Dey, Year)

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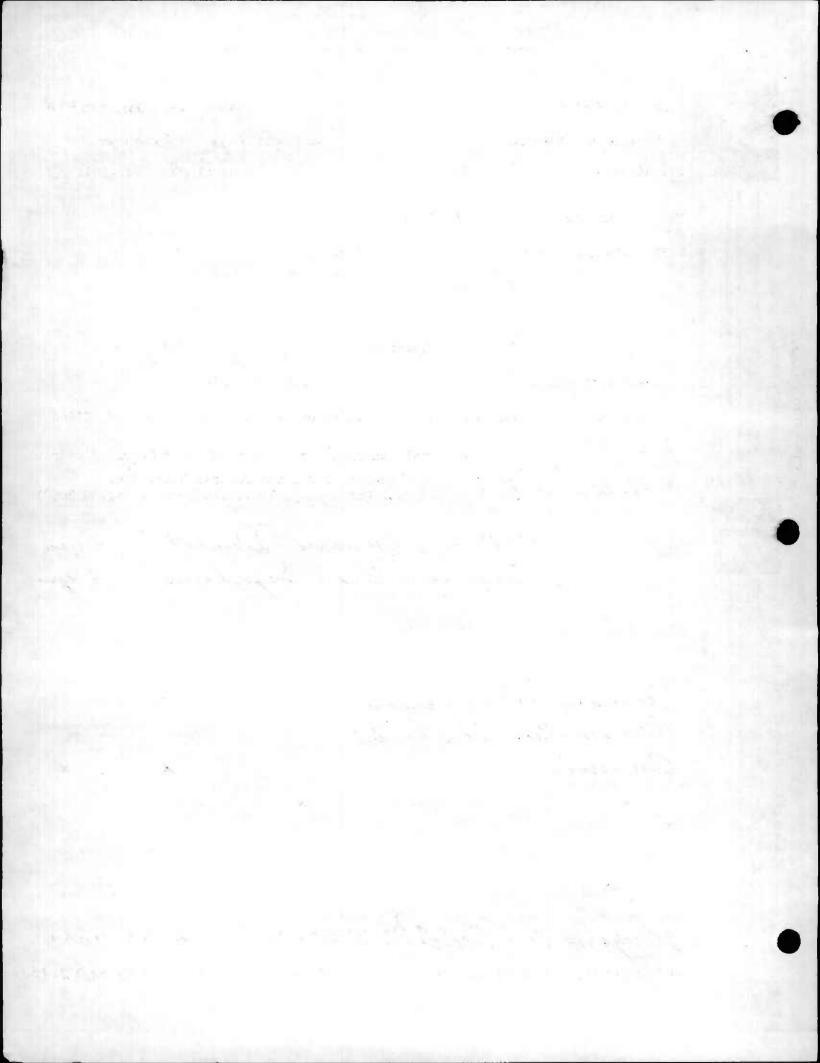
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

32. Registrar's Signeture

Mostales, Luch

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Zeta Juanita Young May 2000 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sacred Heart Home Prince Georges Hyattsville 5. Social Security Number If Under 1 Year If Undar 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Hours 1 M XXF Director 80 236-28-2351 Jun. 11, 1919 Kentucky Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Prince Georges Hyattsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 Queens Chapel Rd. permit. Pages 1 and 2 should be filed within 72 hours after death vigorement of Health and Mental Hygiene. Important If them 27 is marked other than "natural", or item-USA Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Biack, White, etc. XX Never Married 2 Married Baltimore, Maryland 21215-0020 Specify White 1 ☐ Yes XX No Specify: þ 3 Widowed 4 Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Radio Operator Airline 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Sumema) Be (unobtainable) (unobtainable) 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, State, Zip Code) Maryanne Fay/ Friend 2228 William & Mary Dr. Alexandria, VA 22308 20e. Method of Disposition 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removei from State 4 ☐ Denation 5 ☐ Other (Specify) Mt. Comfort Cemetery May 5, 2000 Alexandria, VA 22. Name and Addrass of Facility Affordable Funeral Services PO Box 542 Merrifield, VA 22116 23a. Part1. Enter the disease, or complicate shock, or fleast tailure. List only are ons that caused the death. Do het enter the moda of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Cause (Finel CONGESTIVE HEART FAILURE MONTHS diseese or condition resulting In death) Examiner Examiner ATHEROSCIEROTIC HEART DISEARE DECADER certificata be executed -tran Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaase or Injury that initiated events resulting in deeth) Lest pue Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical Dua to (or es e consequenca of): P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTA Records, þ Be Completed 24b. Were eutopsy findings evelleble prior to complation of causa of deeth? 24a. Wes en eutopsy performed? paga 2 this certificate 1□ Yes 2 No 1 Yes 2 No Vital Hospital or Attanding Physician: 24 hours after death.
Puneral Director: After this certifical etally filled in by the funeral director. 25. Wes case referred a medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Division of 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, end due to the cause(s) end menner es steted.
2 Medicat Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, deta and piace, end due to the cause(s) and manner steted. cai 29e. Certifies (Check of one) 29b. Signatupe 29c. Licansa number 29d. Data signed (Month, Day, Yaar)

7500 CREENWAY CTOL OR GREENBEITME 20770

State Registrar

Name end address of person who completed cause of death (Item 23e) (Type, Print)

AND

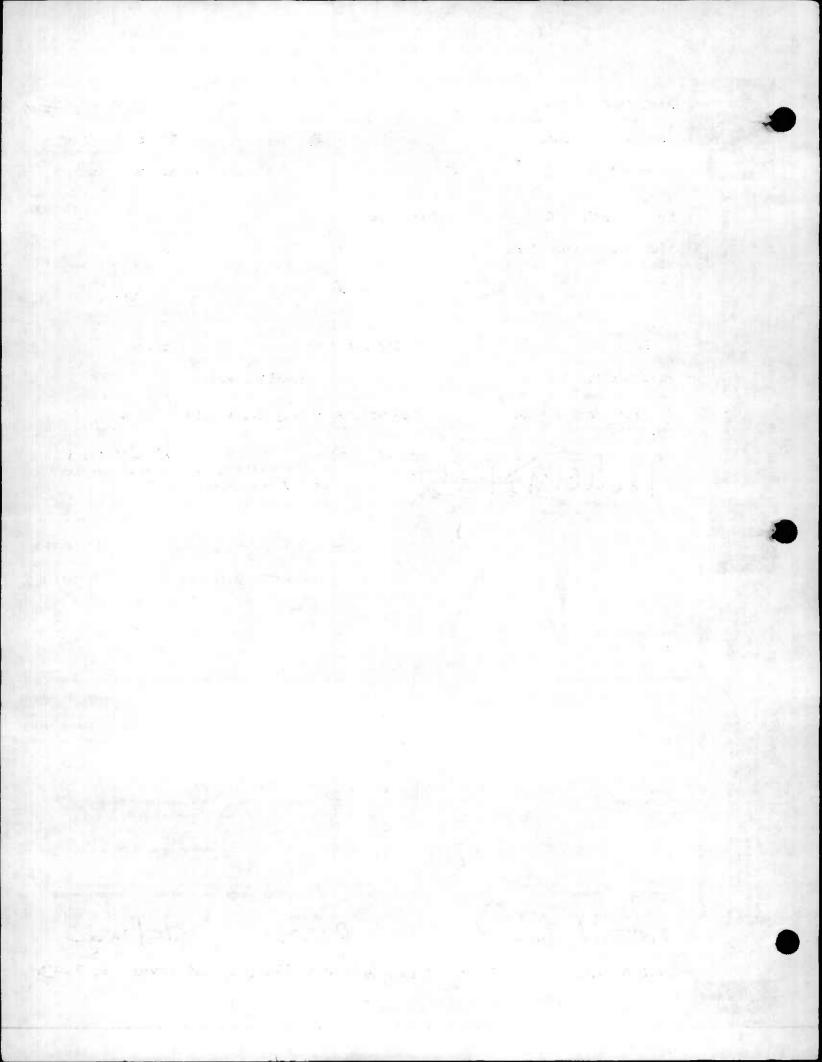
32. Registrer's Signeture

VERER A JCHISLER

0 5 2000

31. Dete filed (Month, Dey, Yeer)

MAY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Daath Day 28 2000 Month 15/Am ounabloo DIVUR 04 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daeth 4c. County of Death Long View Nursing Home Manchester Carrol1 If Under 1 Yaar 8. Data of Birth (Month, Day, Year) OCT. 23,1919 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) Months Days Hours 1√2 M 2□ F 214-16-7332 80 Yrs. Maryland Usual Rasidanca of Dacadan 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits X⊠ Yas 2 No Maryland Carroll Manchester 10e. Straat and Number 10f. Zip Code 10g. Citizan of Whet Country? 3332 Main Street 21102 United States 12. Was Dacadant Evar in U,S. Armed Forcas? 1≥F/as 2 □ No If Yas, Giva Yaar or Datas:1942-43 13. Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Rece - Amarican Indien. Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2KMo Specify: 3℃Widowad 4 Divorced White 16a. Dacadant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Salesman Hardware 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Oliver W. Youngblood Bessie McDonald 19a. Informant's Nama/Ralationship (Type, Print) Scarlett J. Bean/ Daughter 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 3251 Gamber Road Finksburg, MD 21048 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Cedar Hill Cemetery 05/01/00 4 Donation 5 Other (Spare Suitland, MD 22. Nama end Address of Fecility Takoma Funeral Home 254 Carroll St. NW Washington, DC 20012 IND. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximeta Interval Batwaan Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Myo com La Dua to (or as a consaquence of) ASWD Dua to (or es e consequance of): Due to (or as a consequanca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit

requires that the death certificate be axed P.O. Box 68760.

The law

After this certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completally filled in by the funeral director,

Division of Vital Records.

Examiner

Physician/Medical

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Completed

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Certification:

Medical

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene.
Important: If term 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Madical Examine in mail be notified at

Baltimore, Maryland 21215-0020

Sequantially list conditions, if eny, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

25. Was casa referred to medical

steren 31. Data filed (Month, Day, Yaar) MAY 02 2000 24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

1 🗆 Yas 26. Pieca of Daath (Check only ona) 1 ☐ Yes 2 ☐ No

axaminar? 1 ☐ Yas 2 ☐ No	Hospital: 1 Inpatiant 2	ER/Outpetient		1: 4 Nursing Homa		8 Othar (Specify)
Mannar of Deeth	28a. Data of Injury	28b. Time of	28c. Injury	et 28d	. Dascribe how in	ury occurrad

ry occurrad 1 Natural 5 Panding invastigation Work? 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba 3 Suicida 28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata)

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida 29a Certifiar

Certifying Phystolan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

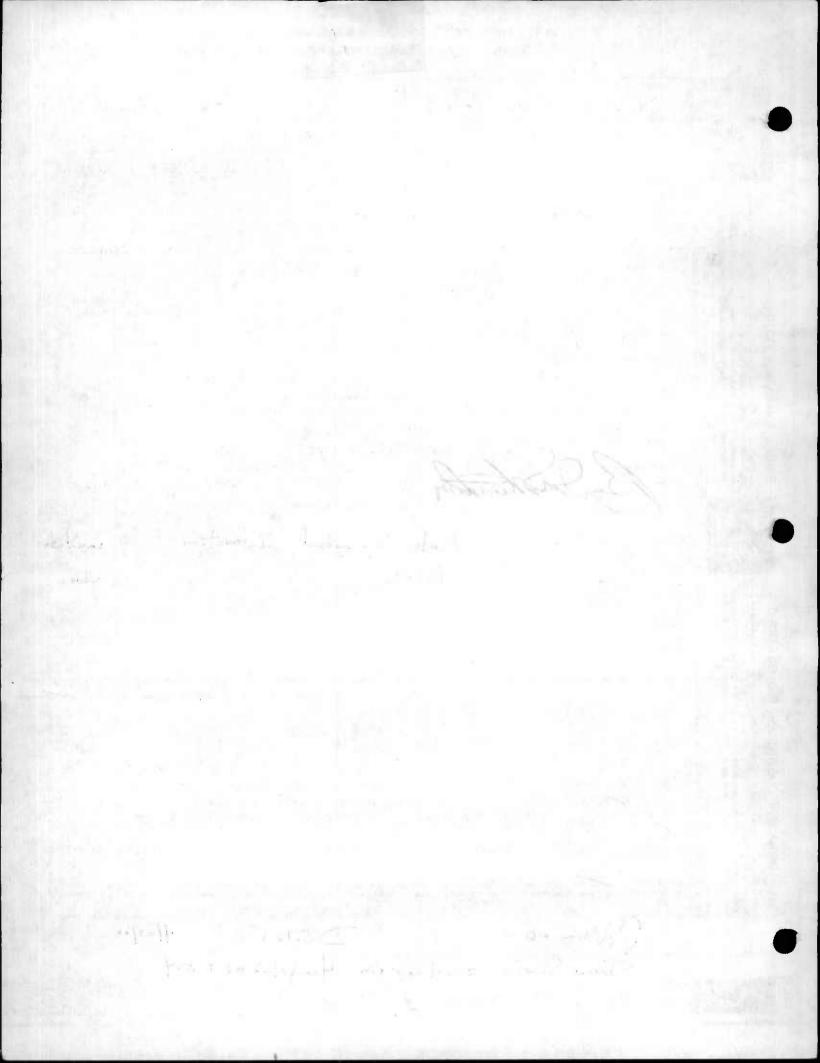
(Check only one)	2 ☐ Medical Examiner:	On the basis of axamination and/or invas and mannar stetad.	tigation, In my opinion, death occurred at the ti	urrad at tha tima, data and place, and dua to tha caus		
29b. Signature a	ed titia of certifiar		29c. Licanse number	29d. Data signed (Month, Day, Year)		

30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print) ZIII Hamore Pite

33165

State Registrar

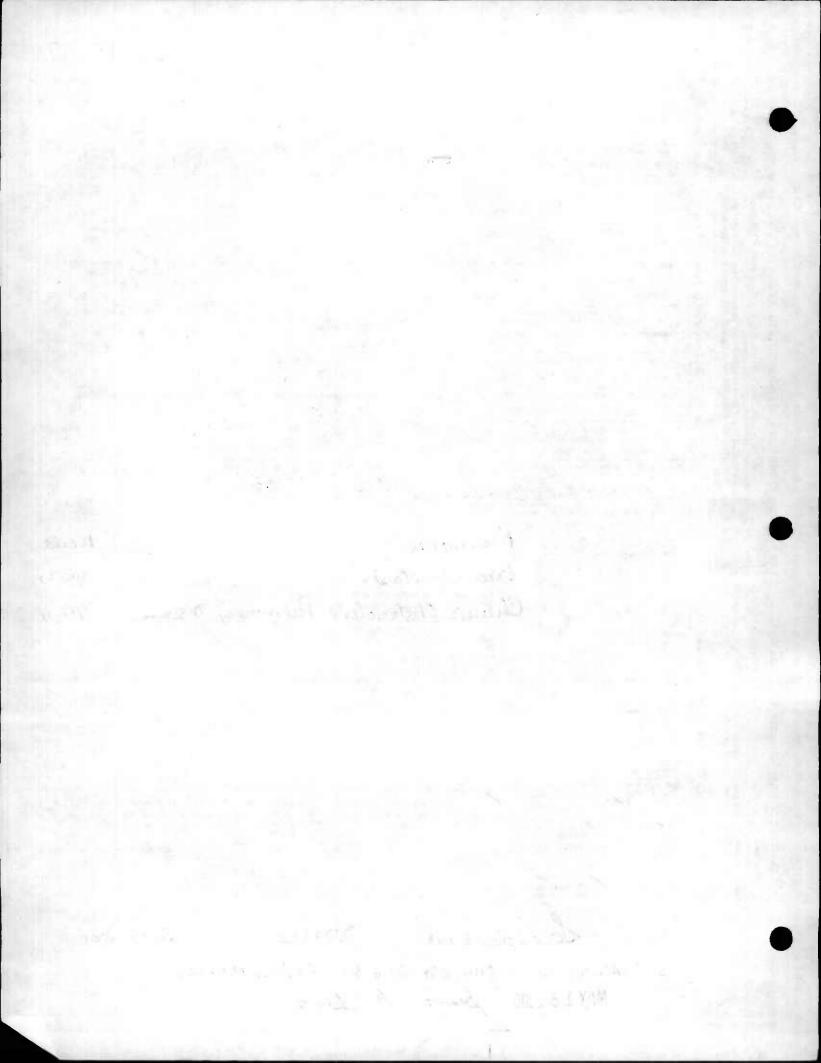
32. Begistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amended item #7 per anatomy board g783 5/18/2000 ah Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FRANK W. BOSTWICK 0540 MAY /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL UNION HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Sept 18, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 85 yrs. 6. Sex 1 M 2 ☐ F **Funeral** MD 199-07-5836 Director Usual Residence of Decedent 10a, Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Medical Examinar must be notified at MD Cecil North East 1 Yas 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 411 Cecil Avenue 21901 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indien. Bleck, White, etc. filed within 72 hours after 1 Nevar Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Yeer or Detes: 33-42-45 Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Capatiment of Health and Mental Hygiene. Important it flem 27 is marked other than any Injury or other trainment. Elementery/Secondary (0-12) College (1-4or 5+) electrician electrical 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) å John W. Bostwick Mary R. Tuttle 19e. Intorment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elsie Bostwick/spouse 411 Cecil Avenue North East, MD 21901 Saltimore. 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Melhod of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel trom State 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signature of Francis Trace Som Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pel 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shick, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) 1 neumonia /Medical Weeks Examiner Due to (or es e consequence of): Bronchiactasis years physicien and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In death) Last Obstructive Pulmonary Discouse Box 68760. that the death certificate be Physician/Medical 88 signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy tindings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed Deen 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 10 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 ☑ Neturel 28d. Describe how injury occurred To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28b. Time of Certification: 28c. Injury at Work? After 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end mennar steled. edicai 29e. Certifier (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number Sachder 8 MB 5. 15. 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) S.S. SACHDENMD, Elkton M12/92/ 118NorkSt Suite 31. Dete tiled (Month. 32. Registrar's Signeture State 2000 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** Leo Joseph Beaumont, Jr. 2000 3:48 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Home Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex Birthplaca (Stata or Foraign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F Months Days Hours Yrs 112 32 2669 Director Jan. 8, 1941 Massachusetts Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yas XX No Director Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6131 Rainbow Dr. 21075 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Black, White, atc. 1 Never Married 2 Married 1 Yes 2√ No Specify Specify: white Be Completed by 3 ☑ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Investigator 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumema) and 2 should be filleelth and Mental H Leo Joseph Beaumont, Sr. Catherine Hourthan 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jean Dengler daughter 6131 Rainbow Dr., Elkridge, MD 21075 permit. Peges 1 a Department of He Important: If Nem eny Injury or oth 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Pk. 5/20/00 Elkridge, MD 22. Nama and Address of FacilityGary L. Kaufman Funeral Home @ 21. Signature of Funeral Service Licenses MOIOST Meadowridge Mem.Pk.,7250 Wash. Blvd. Elkridge MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** bstructive Lung disease Immediata Causa (Final diseasa or condition resulting in death) /Medical SYKL Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 29 24b. Wara sutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No of Vital director. 25. Was case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) To Sport Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yas 25 No this 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of 28a. Deta of Injury (Month, Dey Year) Division 5 ☐ Pending invastigation Attending 1 Natural ne Hospital or Attending in 24 hours after death. The Funeral Director: After pletely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, Steta) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only 29c. License number 29d. Date signed (Month, Day, Year) wy 5990 ed cause of the ath (Item 23a) (Type, Print) · 16.184 6.Bmc N. Cha 6701

State Registrar DHMH 16 Rev 6/95

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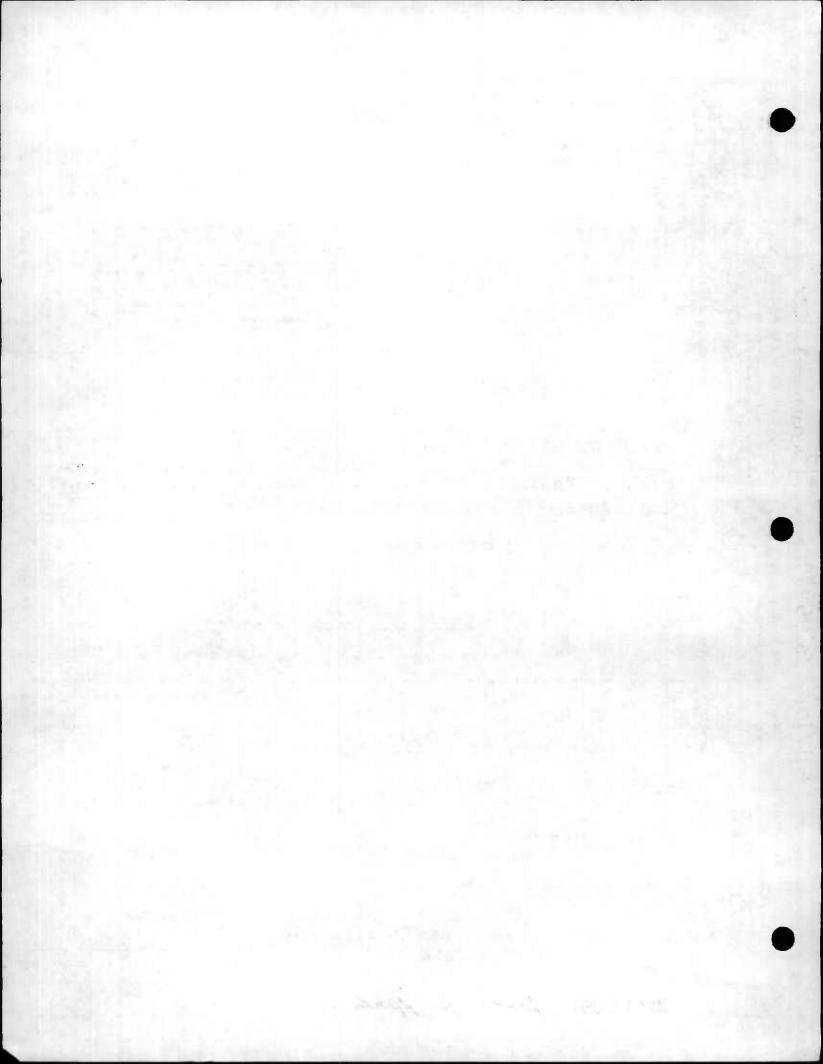
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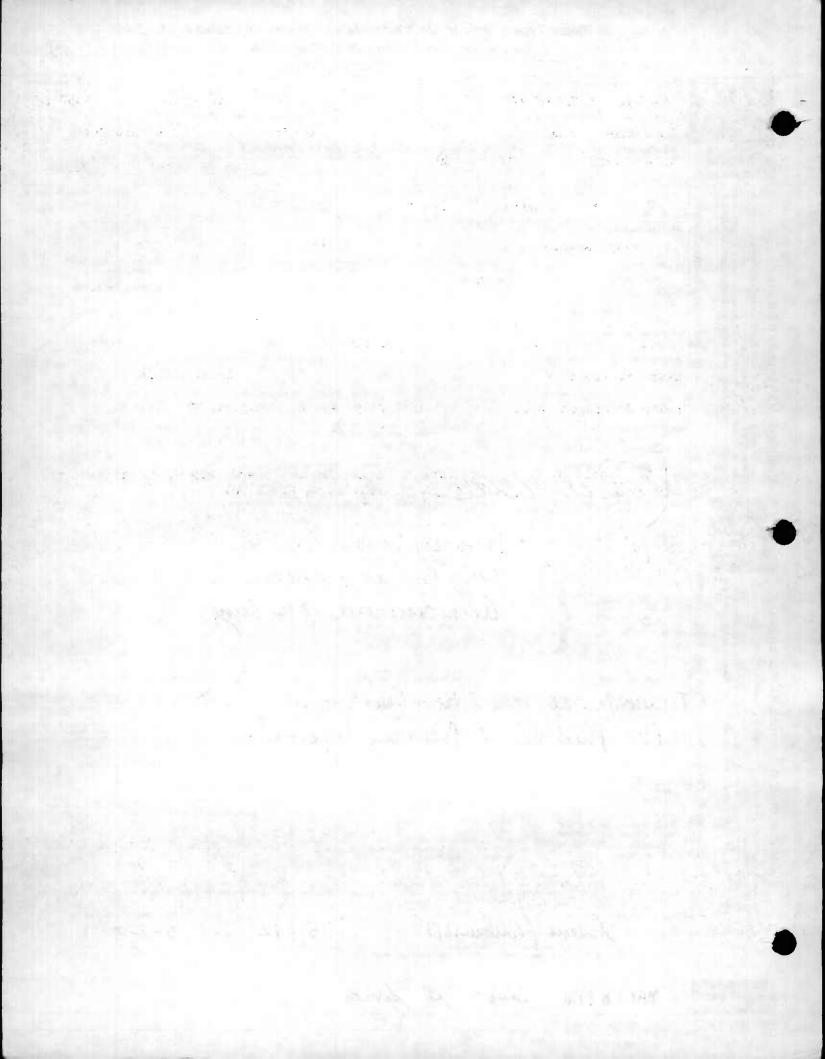
32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene amend item 24a,25,26,27,29a,30 per phys. G783 5/18/00 ygCertificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death MAY 5, **Physician** 2000 VIRGINIA BRECKENRIDGE 8:50 PM * /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Daath Examiner 1517 Elwyn Avenue Crofton Anne Arundel If Undar 1 Yaar If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dafa of Birth (Month, Day, Year) **Funeral** Days 451-20-7220 1□M 2X F 80 Yrs Director May 31, 1919 Usual Rasidanca of Decedant with the Merylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits evant, the Medical Examiner dust be notified at MD Anne Arundel Crofton 1 Yas 2X No Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 1517 Elwyn Avenue 21114 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14 Race - American Indian Black, Whita, atc. Med within 72 hours effer 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Marriad Maryland 21215-0020 1 ☐ Yas 2 No Specify: white by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elamantary/Sacondary (0-12) Collaga (1-4or 5+) housewife unk none unk permit. Pages 1 and 2 should be life Department of Health and Mental Hyo Important! If Item 27 is marked any Injury or see 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fafhar's Nama (First, Middla, Last) Be Lucille Onion Henry A. Trost 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21114 1517 Elwyn Avenue Crofton, MD Helen Grande/daughter Baltimore, 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 X Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
State Anatomy Board 655 W. Baltimore Street Ropald S. Wade Director Baltimore, MD 21201 Approximata Intarval Batwaan Onser and Death Part 1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. nysician Immadlata Causa (Final disaasa or condition rasulting in daath) /Medical Kulumay Vascular Examine: Due to (or as a cons Examiner Resonatory law requires that the death certificate be executed buriel-transit Sequantially list conditions, if any, leading to immediate cause. Enfar Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequanca off: pue Records, P.O. Box 68760, physicien alurcarcinema Physiclan/Medical es the Dua to (or as a consaguanca of): deleched fecuse Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown rquigitation found to severe þ should be 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy Completed Pulmonary Hype peen page 2 hes certificete 1 Yas 2 No 1 □ Yas 2 □ No Division of Vital director, 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 8 ☐ Othar (Specify) 2 1 Yas 2K No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: After 5 Panding Invastigation 1 Natural Hospital or Attandin 124 hours efter deeth.
 Funeral Director: Aft 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify) filled in by 4 | Homicida 15 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Cartifiar Medical 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifiar . Wounders 050872 5-9-00 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Barbara P. Urban 1684 Village Green Crofton, Maryland 21114 31. Date filed (Month, Day, Yaar) WAY 1 8 2000 32. Ragistrar's Signatura Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5940 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:00 P.M. MAY 15, HOMER BUCKNER 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4263 LABYRINTH ROAD BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Sex 7. Age (In vrs. lest birthday) 8. Data of Birth (Month, Dey, Yeer) **Funeral** Hours Months Days 1 X M 2 □ F Yrs. Director 216-01-6693 AUG. 10, 1918 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show 1 ¥ Yas 2 No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23s or in yor other traumatic event, The Medical Examiner ment ha 4263 LABYRINTH ROAD 21215 U.S.A. by Funeral 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or Not Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - Americen Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest grade complated) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN CHARLES FISH & CO. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be **ALEXANDER** BUCKNER ELSIE HACK 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Numbar, City or Town, Stete, Zip Code) TOBY BUCKNER / WIFE 4263 LABYRINTH ROAD - BALTIMORE, MD 21215 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Department of F Important: If the any Injury or off 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEMETERY 5/17/00 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate tritarval Batwean Onset and Daath Do not anter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical immediate Cause (Final disease or condition rasulting in death) Examiner Examine physician and the bunal-transit The law requires that the death certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 3 CV E Box 68760. Physician/Medicai Due to (or as a consequence of) 980 P.O. 23b. Did tobacco ase contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 20 3 Probably 4 ☐ Unknown 1 Yes Records, þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed cate has t 1 ☐ Yas 🔾 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Daath (Check only one) examiner? Hospilal: Other: 4 Nursing Homa 5 Nesidence 6 Other (Specify) 2[Certification: To 1 Yas 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Dascribe how Injury occurred 27. Magner of Dea 28b. Time of After 5 Pending investigation tnjury Natural after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Streat end Number or Rural Route Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Cartifier Certifying Physician: To tha best of my knowladga, daath occurred at the tima, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) Medical

Registrar DHMH 16 Rev 6/95

29b. Signature and title of certifier

OND MOR 31. Date filed (Month, Dey, Year)

MAY 1 8 2000

pleath (Item/23a) (Type, Print)

License number

29d. Date signed (Month, Dey, Year)

and manner stated

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32. Registrar's Signatura

ress of person who completed saula

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day 5 Month Year **Physician** ark 10:47 0 am /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, give street and number) Hospital Baltimore Baltimore Maryland niversit ot If Undar 1 Yaar | If Undar 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 5. Social Security Number **Funeral** 18 M 2□ F 47 416-74-3790 Director 23 Indiana Usual Rasidance of Decedant death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Insida City Limits items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No N/A Director Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1926 Wilhelm Street 21223 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) Race - Amarican Indian, Black, Whita, atc. Was Decedant Evar in U,S. Armed Forcas? pernit. Pages 1 and 2 should be filed within 72 hours effer Department of Heelih end Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. The market is presented. 1 ☑ Yas 2 ☐ No If Yas, Giva Year or Datas: 1 Nevar Marriad 2 Married 1 ☐ Yas 2 No Specify: Specify: White Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Painter Trade/Home Improvement 10 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Donald Charles Clark Ida M. Singleton 2 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ratationship (Type, Print) Christina Clark - daughter 1926 Wilhelm St., Baltimore, Md. 21223 20b. Ptace of Disposition (Nama of Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition cematary, cramatory or other placa) 5/24/00 1 A Burial 2 Cramation 3 Removal from Stata Crownsville Veterans Cemi Crownsville, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signature of Funeral Sarvice Licenses mo1050 7250 Washington Blvd., Elkridge, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath **Physician** Immediata Ceusa (Final disaasa or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner eumonia Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last use es the buriel-tren Due to (or as a consequence of): end attending physician IVer -ailur Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nhknown signed by þ 24b. Wara autopsy findings availabla prior to complation of cause of daath? funeral director, page 2 should rtification: To Be Completed 24a. Was an autopsy performad? After this certificate has 1 Vas 2 No 1 Yas 2 No 25. Was casa rafarred to medicel 26. Placa of Daath (Chack only ona) Hospital: 1 Inpatient Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Spacify) 1 Yes 2 No 2 ER/Outpatiant 3 DOA 26a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural Injury efter death.

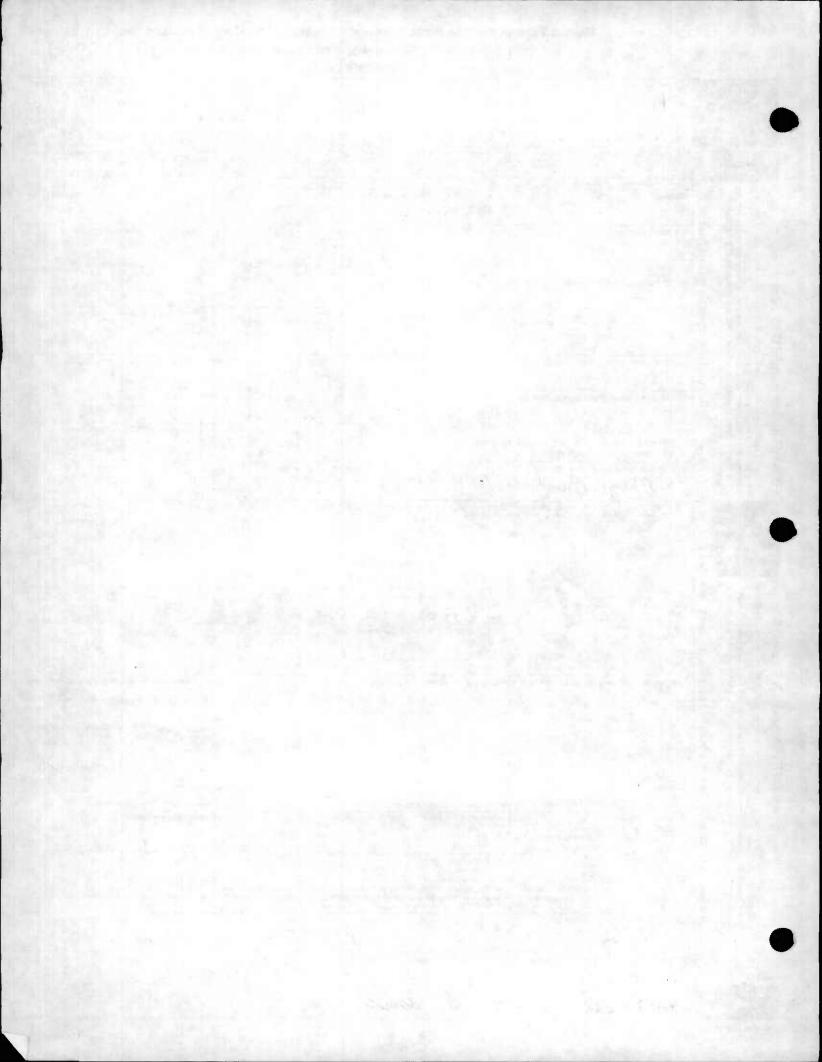
Director: Aft
d in by the fur 1 Yas 2 No 2 Accidant 6 ☐ Could not be 3 Suicida 28f. Location (Straat and Numbar or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

We Funeral Dietely filled edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
comp comp	29b. Signatura and the of certifiar Amith mo	29c. Licansa number P13374	29d. Data signad (Month, Day, Year) 05/15/00							
	30. Name and addrass of person who completed causa of daath (Item 23a) (Type, University of Mary (200	22 South Gr	eene St.							
State Registrar	MAY 1 8 2000 32. Registrar's Signatura	ch								

24



Division of Vital Records, P.O. Box 68760,

State Registrar

29b. Signeture end title of certifier

200 Nospital Mn 32. Registrer's Signature

MO

who completed ceuse of death (Item 23e) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

Suite 409 Glan Burnie, mo 21061

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 15943

	Certificate of Dea	nth i	Reg. No.							
	1. Decedent's Name (First, Middle, Last)	2. Data of De Month	ath Dev Yaer	3. Tima of Death						
Physician /Medical	Catharine L. DiBlasio	May 16, 2000								
Examiner	4a Facility Nama (II not institution, giva street end number) 4b. City	y, Town, or Location of Deeth	th 4c. County of Deeth							
	Homewood Genesis Ba	ltimore	timore N/A							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 1 Yee	nder 24 Hrs. 8. Date of Bird	th 9. Birt	thpleca (Stete or Foraign						
Director	219-16-9064 1 M 200 F 74 Yrs. Months Deys Hou	Sept.1	1,1925 Mar	yľánd						
p ,	Usual Residence of Decedent			Local Marie Constitution						
ahow	10a. Stete 10b. County 10c. City, Town or Location			10d. tnside City Limits 1X Yes 2 □ No						
or 28a-f short and instituted and in	MD N/A Baltimore									
or 2	10e. Street and Number 10f. Zip Code	INC.	10g. Citizen of Whet Co	ountry?						
72 hours after death with the Maryland natural", or frems 23e or 28e-f show steal Examiner must be notified a sted by Funeral Director	6000 Belona Ave. 21212		United States							
al', or items Engineering by Funer	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic If Yes, specify Cuben, Mex	c Origin? (Specify Yes or No xicen, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.							
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iges 1 and 2 should be filed within 72 hc fleath and Mental Hygiene. If item 27 is marked other than "nature or other traumatic event, for Medical TO Be Completed				Zip Code)						
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permit. Pages 1 and 2: Department of Health at Important; if them 27 is any injury or other treu- once.	1 Buriai 2XXCremation 3 Removel from Stete cametery, crametory or other plece)									
tmer thant			5/18/00 Beltsville, MD							
permit. Pag Department Important: I any Injury o	21. Signeture of Furgerei Service Licensee 22. Nama and Address of Facility CAFA-Stephen D. Lohrmann P.A. 8717 Green Pastures Dr. Baltimore, MD									
00240	ama C. Harderty 8717 Green Pa	altimore,MD	21286							
	23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	h es cardiec or respiretory e	rrest,	Approximete tritervel Between Onset end Deeth						
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/Medical	Immediate Cause (Final disease or condition									
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executed in and inal-transit	Sequentially list conditions, Due to (or es e consequence of):									
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or Attending after death. Director: After din by the fune	3 Suicide 6 Could not be determined 28e. Place of thiury - At home, farm, streat, factory, office	28f. Location (Street end Number or R	Rural Route Number,						
afte Direction	4 ☐ Homicide building, etc. (Specify)	City or To	wn, Steta)							
pours fille	29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, det	te end place, end due to the	ceuse(s) and menner e	s stated.						
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be ((Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, and menner steted.	, deeth occurred et the time,	dete end plece, end due	e to the cause(s)						
Vithin omple	29b. Signature end title of certifier 29c. License number	ber	29d. Deta signed (Mont	th, Dey, Year)						
- > - 0	mariles 1 1 Agence un Nous	-10	5/17/10)						
9	30 Name and address of person who complained areas of death /lies 200 Trans Point	18	7/1/100							
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MANUTA C. YCAYHUNDO 2007 T. NION A FILE	A Andrews	call A.	102148						
	31. Data filed (Month, Dey, Year) 32. Registrar's Signeture	in Carhinay	aummer 19	11/2/01/						
State Registrar	MAY 1 8 2000 Server & Sparks	-/-								
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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended item #77per anatomy board g783 5/18/2000 ah Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Year Month Physician HENRY P. EVANS 14 3:55 PM Mar 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Baltimore HOSTITA 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth March 6, 1914 5. Social Security Number Birthplace (Stata or Foraign Country)
 NO **Funeral** 1X) M 20 F NC 212-05-8529 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits in and Mental Hyglene.
7 is marked other than "natural", or itsens 23s or 28s-f show traumetic event, the Medical Examiner must be notified at MD N/A Baltimore 1X Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 W. Belvedere Avenue 21215 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married aticat known as Henry Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: black þ 3 NWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer none permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if fem 27 is marked othe
any injury or other traumetic event,
9005s. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Louvenia Henry Pettigrew Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Henrietta Harcum/daughter 6527 Eberle Dr #201 Baltimore, MD 21215 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 5 Other (Specify) 21. Screet and Gruperal Service Licensee
Ronald S. Wane Direct 22. Nama and Addrass of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediata Cause (Final a. Myocardial Into disease or condition resulting in death) Examiner Examiner attending physician and for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the a 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 X No certificata of Vital director, 25. Was cese referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Dunpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this After thi 27. Manner of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation 1 Yas 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 C Homicide 13 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funera

State Registrar

(Check only

29b. Signature and title of certifier

31. Data filed (Marth, Pay, Year) NAY 1 8 2000

Weber,

Sinai Hospital 32. Pegistrar's Signatura

Weber Do

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

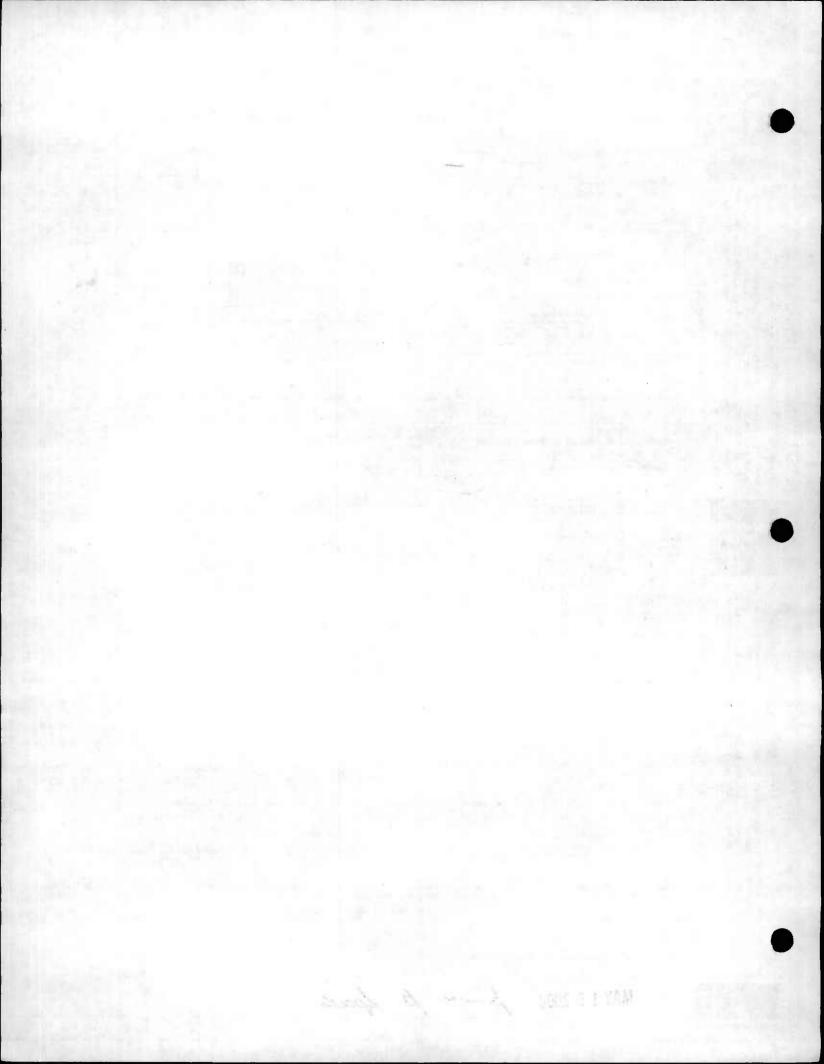
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29c. License number

RES-OOC

29d. Data signed (Month, Day, Year)

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Year 2000 12:19 MAY 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Baltimore GNES HOSPITAL If Under 24 Hrs. Birthplece (State or Foreign Maryland 5. Sociel Security Number If Under 1 Year 8. Dete of Birth Month Day May 27, 1909 (In yrs. last birthday) 1 MX 2 F 216-12-0653 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Elkridge 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21075 U.S.A. 5765 Main Street 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Meritel Stetus Bleck, White, etc. X□ Never Married 2□ Married 1 ☐ Yes X₂ ☐ No Specify: White If Yes, Give Year or Detes 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Samuel Newton Earp Annie Olivia Tilghman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6440 S. Trotter Road Clarksville, Maryland 21029 Mrs. Edith Parlette 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete X Buriel 2 Cremetion 3 Removel from State 05/15/00 Elkridge, Maryland Melville Chapel United Methodist 4 Donetion 5 Dother (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licen MOIII3 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death e. PERITONITIS WITH MRSA AND VRE, SEPSIS

Due to (or es a consequence of):

S/P Sigmoid volvulus Rupture, Colectomy, cholecystectomy

Due to (or es e consequence of):

COPD, CAD with valvular hert disease. DNR/DNI Immediate Ceuse (Final disease or condition resulting in deeth)

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events.

Pert II. Other significant conditi	ons co	ntributing to death but not re-	sulting in the underlying	cause given in Pert	l.		ntribute to the cause of death		
						1□ Yes 2No	3 Probably 4 Unknow		
						24a. Was an eulopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?		
						1 ☐ Yes 2 🕅 No	1 ☐ Yes 2 No		
25. Wes case referred to medical examiner?	al _			26. Plac	e of Deeth ((Check only one)			
1 ☐ Yes 2 No	ŀ	lospitel: 1 Inpatient 2	ER/Outpatient 3□ D	OA Other: 4 N	ursing Home	e 5 Residence 6 Oth	er (Specify)		
27. Menner of Deeth 1 Maturel 2 Accident 3 Suicide 4 Homicide 2 Pending investigetio 6 Could not be determined		28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?		28d. Describe how injury occurred			
		28e. Plece of Injury - At h building, etc. (Speci	ome, ferm, street, fecto	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)					

To the Hospital or Attending Physician: The law requires that the death cartificats be associted within 54 hours stard dash.
To the Funeral Director: After this cartificate has been signed by the attending physician and complataly littled in by the funeral director, page 2 should be deteched for use as the burial-transit complataly littled in by the timeral director, page 2 should be deteched for use as the burial-transit Ž State

Division of Vital Records, P.O. Box 68760,

VYACHESLAV 31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

FUZAYlov

AS 2438528-1186

29c. License number

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Caton AVE, BAH: MORE, MD 21229

MAY 1 8 2000

MD, SURGICAL RESIDENT

DHMH 16 Rev 6/95

Registrar

X X

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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	aminer	4s Fscility Neme ((If not institution,	give street end nu	im <i>ber)</i>			4b. City, To	wn, or Loc	cation of Deeth	4c. County			
Sec. 1		The	Memori	al Hosp	ital			Eas	ton		Tal	bot		
Fune	eral	5. Social Security I	Number	5. Sex 1XIM 2□ F	7. Age (In yrs.		Months Deys	If Under:	24 Hrs. Min.	8. Dete of Birth (Month, Day	Year)	9. Birthp	lece (Stete or Foreign try)	
Direc	tor	212.05.21		IQIM ZLIF	84	Yrs.				Oct.16,	1915	Mary		
pu .		Usuel Residence of 10a. Stete	10b. County		10c. Cit	y, Town or Lo	ocation	-				11	0d. Inside City Limits	
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15e	Director	10e. Street end Nu		<u></u>			10f. Zip Code			1	Og. Citizen of \	Whet Cour	ntry?	
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020 urs efter N', or fte	yland 21215-0020 uld be filed within 72 hours effer of Mentel Hygiene. riked other then "natural", or the rist event, the Medical Examines TO Be Completed by Fur	1 ☐ Never Men	ried 2 Merrie	Armed Forces? 1 Yes 2 No WW If Yes, Give Yeer or Detes:		in U.S. 13. Was Decedent of Hispanic Origin? (S It Yes, specify Cuban, Mexican, Puerl				Rican, etc.)	Specify	ck, White, v: W	etc. hite	
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Balt. Departing	OD CO	21. Signeture of Fungal Service Licenses 22. Name end Address of Fecility 7250 Washington												
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Box 6 eath certific	S C S			0.										
o de	Physician/M	Pert II. Other eigni	ficant condition	contributing to d	leath but not resi	ulting in the u	nderlying cause giv	en in Pert I	l.	23b. Did to	obacco use co	ntribute t	the cause of death?	
ds, P.O. Box 6 ires that the death certific signed by the attending p	y Ph		2015	De 18 2						1 🗆 Y	'ee 2□ No	3☐ Pro	bably 4 Unknown	
TOC need	lete			181						24e. Wes e	en eutopsy med?	ev	ere eutopsy tindings eileble prior to impletion of cause death?	
I Rec	E O									1 U Y	es 2 No	11	☐Yes 20 No	
Vital F	Be C	25. Wes case rete	rred to medical					26. Plece	e of Deeth	(Check only or	ne)			
of Vita Physician: this certific	ToF	examiner?	No	Hospitel: 1	Jnpatient 2□	ER/Outpatie	nt 3 DOA Oth	er: 4 Nu	ursing Hon	ne 5 Resid	ence 6 Oth	ner (Specia	'y)	
O Physical Control of Phys		27. Menner of Dee		28e. Dete	ot Injury oth, Dey Year)	28b. Time o	f 28c. Injur	y et	2	28d. Describe h	ow injury occur	rred		
ior andin	atic	2 Accident	5 Pending investige	ition	, 20, 100,	qu.y		Yes 2□	No					
Vis Atte	tiffe	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ed 28e. Plece	e of Injury - At ho	ome, ferm, st	reet, fectory, office		2	28f. Location (S City or Tow	treet end Numi	ber or Run	al Route Number,	
D Page	Certification:				mig, oto. (opcom)	,,								
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this certificate he commissely filled in by the funeral director page.	edical	29a. Certifier (Check only one)		caminer: On the b			h occurred et the tir vestigation, in my o							
To the	2	29b. Signeture end	title of certifier	1	.1		29c. Licens		. 1 777	2	29d. Date signe			
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Reg	gistrar		4000	peren	19	do	21							

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Patrick J. Feehley, Sr. 2000 9:37 PM MAY 17, /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07-14-23 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. lest birthday) **Funeral** Months 1 M 2□ F Yrs. 215-18-9156 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be nothing at MD 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9 USA 21219 2707 Bay Dr. 'natural', or items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiane. Eiementery/Secondery (0-12) Coilege (1-4or 5+) Plastics 8 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be is marked of 8 William Feehley Laura Madsen Pages 1 and 2 should 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) parmit. Pages 1 and 2 sh Department of Haalth and Important: If Item 27 is m any injury or other traum DOCE. Mr. Patrick Feehley, Jr. 2707 Bay Dr., Baltimore, MD 21219 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State ty☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Holy Rosary 5-22-00 Balto., MD 21, Signature of Funerel Service License 22. Name and Address of Fecility Kaczorowski Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximete Approximete Intervei Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION 4 DAYS **Examiner** Due to (or as e consequence of): Physician/Medical Examiner STATUS POST RIGHT KNEE REPLACEMENT 7 DAYS Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
24 hours after death.
25 hours after death.
26 hours after this certificate has been signed by the attending physician and attended in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es e consequence of): Box 68760. Due to (or as a consequence of) resulting in death) Lest P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did topacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, b 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Be Completed 24a. Wes an eutopsy 2 No 21 No 1 ☐ Yes 1 Tyes Division of Vital 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manufer of Deeth 1 Meturel 28c. injury et Work? 28a. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edical To the Hosp within 24 hou To the Fune completely fil 29a. Certifier 29b. Signature end title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D 25886 DOC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OFLER DRIVE TOWSON,

DHMH 16 Rev 6/95

State

Registrar

LILIA CEBALLOS.

31. Date filed (Month, Dey, Year)

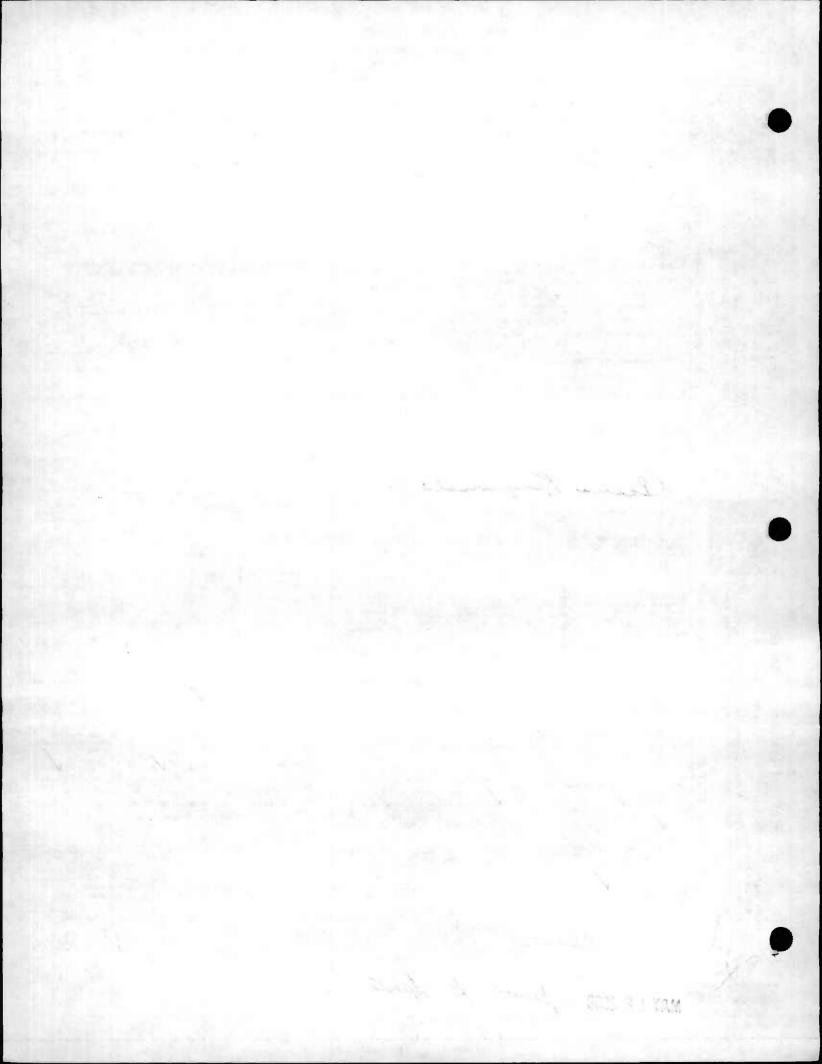
MAY 1 8 2000

M. D.

32 Begistrar's Signature

21204

MARYLAND



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 5948 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** VIRGINIA 9:55A.M FRANK 3000 10 /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital
5. Social Security Number 6. Sex 7. Age (In yrs.) Baltimore Rosedale ent If Under 1 Yeer | If Under 24 Hrs. 8. Data of Birth (Month, Day, July 21 9. Birthplaca (Stata or Foraign Country) MAryland 7. Age (In yrs. last birthday) **Funeral** 1925 Days 1□ M 25 F 74 Yrs. 216-62-8178 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow if item 27 is marked other than "natural", or items 23s or 28s-f above or other traumatic avent, the Medical Examinar must be notified as MD Baltimore Essex 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Herna 23a 946 MIddlesex Road 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural". And any injury or other traument. 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yes 2 € No Specify: Specify: White 3√2 Widowed 4 Divorced rank, Virginia 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 6th 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) 8 William | Fleetwood Mary Kalball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Doris Davis /daughter 946 Middlesex Road Baltimore Md. 21221 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro CrematoryInc.5/18/2000 Baltimore MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221 23a. Part1. Enter Do not antar tha mode of dying, such as cerdiac or respiratory arrest, r the diseas **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical pirator Examiner Due to (or as a consequence of) Examiner neumonia attending physician and for use as the burial-transit certificata be asscuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as e consequence of): Records, P.O. Box 68760 Metastatic LUNG ancer Physician/Medical Dua to (or as a consequence of Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been signed ! by 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 X No 1 ☐ Yes 2 ☐ No certificate of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, b 25. Was casa referred to medical B 26. Place of Deeth (Check only ona) 1 Yas 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA edical Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work? Division 1 Naturel 2 Accident 5 Pending investigation 1 Yas 2 No 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and titla of certified 29c. Licansa numbe 29d. Data signed (Month, Day, Year) 1,2000

State Registrar

30. Nama and eddress of person who

Iam MAY 1 8

DHMH 16 Rev 6/95

Square Drive Baltimore, MD 21237

Franklin

eted ceuse of death (Item 23a) (Type, Print)

1000

32. Registrar's Signatura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month GRANTHAM ENRY MAY 15 2000 4b. City, Town, or Location of Death 4a Facility Name (Il not institution, give street and number) 4c. County of Death GIEN BURNIE ARUNDEL HOSPITAL COUNTY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days Months MM 20F Vns 428-01-7498 1917 MISSISSIPPI 27, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 724 JAMES ROAD 21061 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Black, White, etc. NOTYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2K Married 1941-1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARTILERY SPECIALIST MILITARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WALTER GRANTHAM ZENNIE HOLLOWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BETTYE GRANTHAM (WIFE) 724 JAMES ROAD, GLEN BURNIE, MD. 21061 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5/18/2000 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEMETERY CROWNSVILLE, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 M01220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ular min Due to (or as a consequence of) wo Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

The law requires that the deeth certificate be executed

certificate

After this

death.

24 hours efter death

within 2 To the

Hospital

Records, P.O. Box 68760.

Division of Vital or Attending Physicien: **Physician**

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland pepertnent of Heelih and Mentel Hyglene.
Important: If item 27 is marked other than "natural" and the fraumatic according to the traumatic according to t

Examiner the bunal-transit Physician/Medical cate hes been signed by page 2 should be detect by Completed Be Certification: To filled in by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 8 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated dical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P50P

29d. Date signed (Month, Dey, Year)

2000

State Registrar

completely

Medical

ane)

29b. Signature and title of certified

31. Date filed (Month, Dey, Year)

MAY 1 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

my

32. Registrar's Signature

600

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

D. 1/. D		
DAVID	M.	HISSEY

State of Maryland / Department of Health and Mental Hygiene 15950

Physicia	David M. miss	Last)	PER MEO	Certificat	e ³ ōf	Death		Data of Deati Month	Day 1.4 , 200	Year	3. Time of Death		
/Medica Examine	4s Essility Name //f not lestitution	give street and number)		-			wn, or Location	on of Death					
Funeral Director	5. Sociel Sacurity Number 220-64-2712 Usual Rasidence of Decedent	. Sax 7. Ag	ge (In yrs. last bir	Yrs. If Under	1 Year Days	If Under Hours	Min.	n. (Month, Day, Year) Co			lace (Stete or Foreign try) yland		
e Meryland Sa-f show forland at	10a. Stata 10b. County N/A			10d.									
ath with th	10e. Street and Number 1918 McHenry Street 21223								What Coun				
within 72 hours effer death with the Meryland within 72 hours effer death with the Meryland than "netural", or fearn 23s or 28s-f show he Medical Exercities must be notified at ampleted by Funeral Director		12. Was Decedent Armed Forcas? 1		 13. Was Decedent of Hispanic Origin? (Specify Yas or Note of Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 1 ☐ Yas 2 ☐ No Specify: 					14. Race - Amarican Indian, Black, White, atc. Specify: White				
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	19a. Informant's Name/Relationship Catherine Sheck		ner 19	. Meiling Addrass (Street end Number or Rural Routa Number, Cit 18 McHenry St., Baltimore, Md.									
	20a. Mathod of Disposition 1 Commatter of Disposition (Name of cematary, crematory or other place) 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Security or Other (Specify) 20d. Place of Disposition (Name of cematary, crematory or other place) 20d. Place of Disposition (Name of cematary, crematory or other place) 20d. Place of Disposition (Name of cematary, crematory or other place) 20d. Elkridge, Mc												
Departition of the control of the co	21. Signatura of Funeral Service Licensea 22. Name and Addrass of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, In 7250 Washington Blvd., Elkridge, Md. 21075 23a. Partl. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest. Approximate												
Physician /Medical Examiner but particular and properties and pro	Immediata Ceuse (Final disaasa or condition rasulting In daath) Sequantially list conditions, if any, laading to immediate	a	Dua to (or as a	C INTOX:	ICAT	ION							
certi nding use a	causá. Entar Undartying Cause (Diseesa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): d.												
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aw requ									24a. Wes an autopsy performed? 24b. Wara autops available prince complation of peath?				
Fad	25. Was cesa refarred to medicel	25 Was casa referred to medical								1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
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To the Hospital or Att within 24 hours after d to the Funeral Direct completely filled in by		Physician: To the best aminer: On the basis of and manner sta	of my knowledge axamination and	, daath occurred	at tha tin								
To the within To the compl	29b. Signatura and title of certifier 30. Nema and addrass of person wh	Kind was		SHOW		e number C.M.E	3	29	9d. Data signe MAY	15, 2			
State	THEODORE M. K.	1	111 ar's Signatura	Penn St	reet	, Bal	Ltimore	e, Mary	yland 2	21201			
Registrar	MAY 1 8 2000	Servey	D. A	ball									

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MAY 1 8 2000 James p. fronte

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()
amend item 24a per verbal response G783 5/18/00 yg 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 6 17 p. M **Physician** JACOBI 04 ANDREW 2000 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BON SECOURS HOSPITAL BALTIMORE if Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthpiace (Stete or Foreign Country) **Funeral** Yrs 70 Director 217-26-4720 Dec 8, 1929 MD Usual Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d. inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural; or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Experiment man to notified any injury or other traumatic event, the Medical Experiment man be notified as MD N/A Baltimore Director Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1117 Ellicott Drive 21216 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: þ 3 ☐ Widowed 4 🖔 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Andrew Jacobi, Sr. Jeannette Jeter 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zlp Code) Donna Johnson/stepdaughter unk 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) in Sta in state ature of Funeral Servica Licensee
Ronald S. Wade 22, Name end Address of Fecility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201

In 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final PNUEMIONIA WITH SEPSIS ASPIRATION disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner ARTERIOSCLEROTIL HEART DISEASE UNKNOWN physician end s the bunal-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest Due to (or as e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 ☑ Unknown - PARKINSONS DISEASE signed t Records, by 24b. Were eutopsy findings eveileble prior to completion of cause ot death? P 24a. Was an autopsy performed? ASTHAMA Complet SIP CHASTROSTOMY 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Coutd not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end manner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D 23300 MAY 09 2000 M.D.

State Registrar 31. Date tiled (Month, Day, Year) MAY 1 8 2000

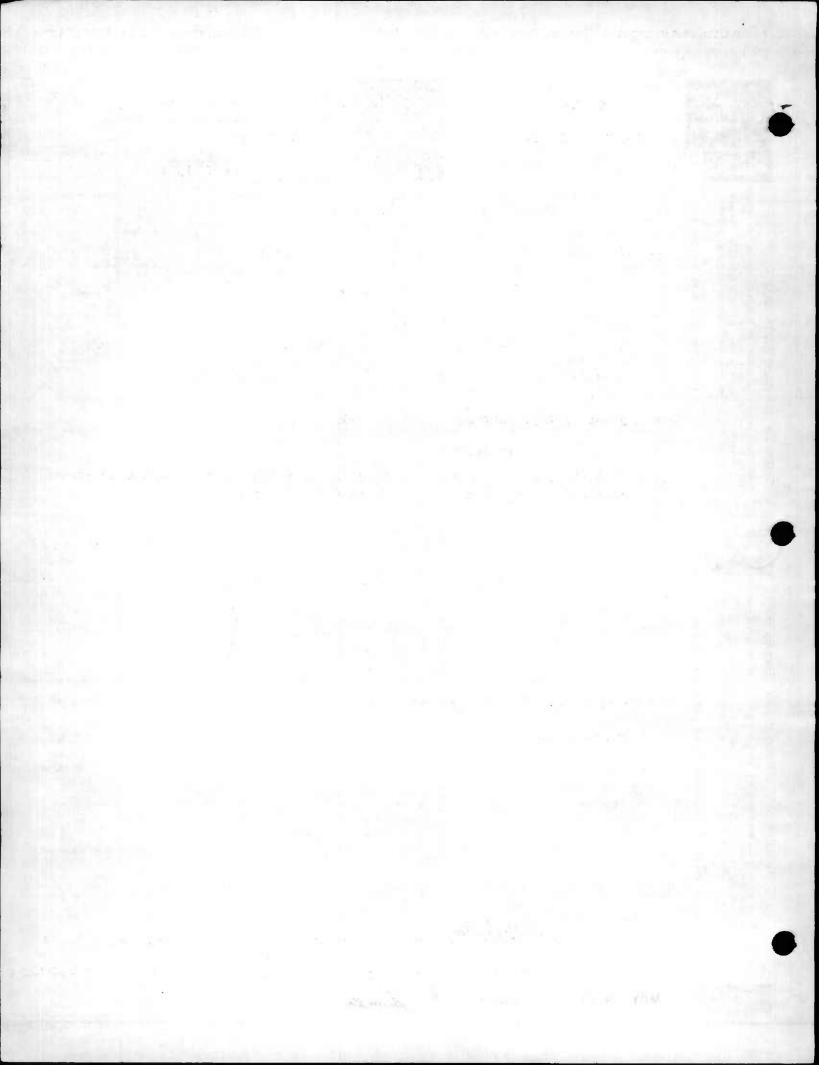
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32. Registrar's Signature

spaces. Baltimore St.

BALTO.MD. 21223

30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print) 13on 3eeo 25 Husp.



1. Decedent's Nama (First, Middla, Last)

Certificate of Death

2. Data of Death

3. Tima of Death

Registrar **DHMH 16 Rev 6/95**

State

29b. Signetura end titla of certifier

31. Data filed (Month, Day, Year)

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JOGINDER P. MEHTA.

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30. Nama and addless of person who complated causa of death (Itam 23a) (Type, Print)

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M. D. , 7601 OSLER DRIVE, 32. Registrar's Signatura

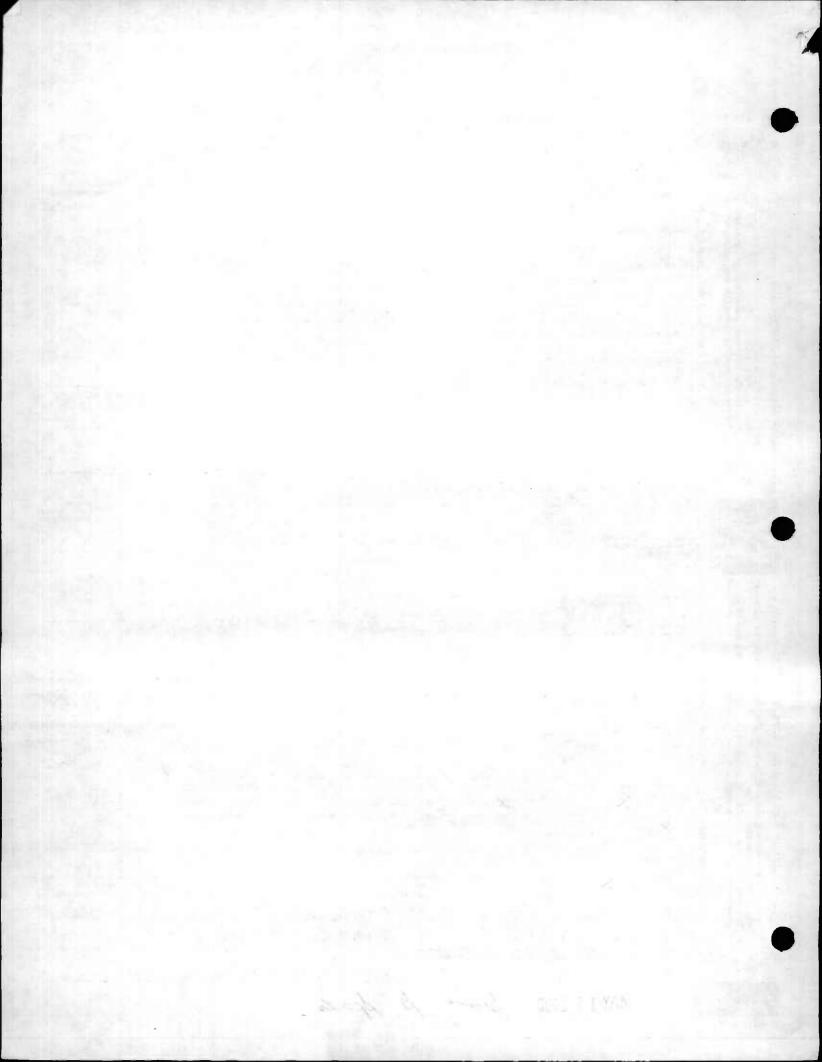
29c. License number

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29d. Date signed (Month, Day, Year)

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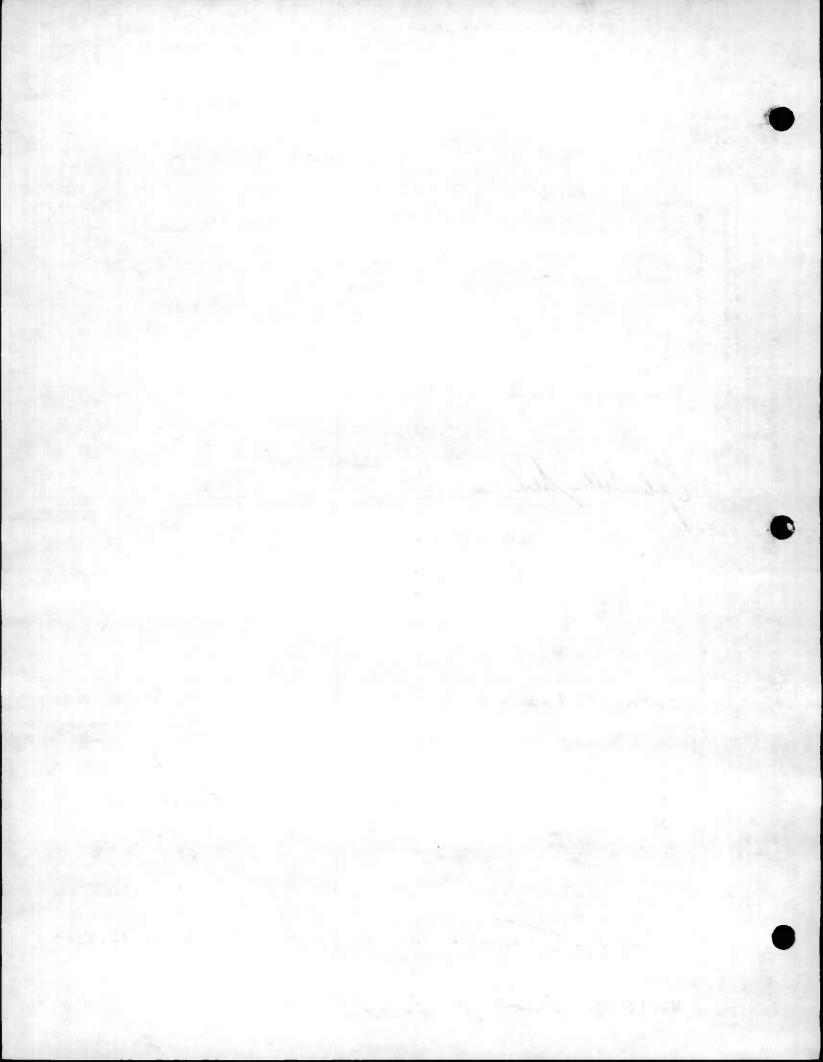
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State of Maryland / Department of Health and Mental Hygiene 15953

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Funeral	5. Social Sacurity Number	8504 Hill Street 6. Sex 7. Age (In yr.	s. last birthday)	If Under 1 Yea			Birth	_	Ward Nace (Stata or Foreic		
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	218-18-0644 X 81 July 1, 1918 \ Usuat Rasidance of Decedent										
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or 28s-f s to notified	Maryland 10e. Street and Number	Howard		10f. Zip Code	Ellicott City	/	10g. Citizen of What Country?				
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should be ind Mental I marked or umatic ava			Pearl Jud	iv							
S D E E	19a. Informant's Name/Ralationshi	p (Type, Print)	19b. Mailii	ng Address (Stree	et and Number	or Rural Routa Nurr	ber, City or Tow	n, Stata, Zip	Code)		
05NB	Ma Milliam I Kin	a III Son		7500South \	/alley Drive	Eairfay Stati	on Virginia	22030			
_ +	Mr. William J. Kin 20a. Mathod of Disposition	Data	pairfax Station, Virginia 22039 Data 20c. Location - City or Town, Stata								
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or the neopting or Attending within 24 hours after demonstration To the Funeral Director. After completaly filled in by the funeral Medical Certification											
n 24 hours w Funeral pletaly filled	29a. Cartifiar 1 Certifying (Check only 2 Dimedical Ex	Physician: To the best of my kn taminer: On the basis of axamin	owledge, death	n occurred at the i	tima, data and p	place, and due to the	e cause(s) and n	nanner as st	ated.		
within thousand to the Funeral completaly filled	The second of th	and manner stated.	ALL STOPOL NO	vosingation, in my	openion, uselli	CONTROL OF DISCOME.	o, data and piace	, and due to	una causa(s)		
Within To the	28b. Signature and title of certifiers		Dent	- 29c. Licer	nse number		29d. Data sign	ed (Month, I	Day, Year)		
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1	20 Name and address 5	The state of the s	7000	Duine)				1-1	2000		
Xh'	30. Nama and addrass of person wi					14B 6 16 15					
DY.		Dep. Med. Ex 4565 I		one Way E	Illicott City,	MD 21043					
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 5 7:00 am George Leader 2000 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 810 S. Ellwood Avenue Baltimore Baltimore 5. Social Security Number If Undar 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Month, Day, Year) 08-07-1923 Birthplace (Stata or Foreign Country) **Funeral** 15 M 2□ F Days Months Hours 215-16-2109 Director Usual Residence of Decedent the Marylend 10b. County 10c. City. Town or Location 23a or 28a-f show 10d. Inside City Limits Director MD n/a 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 810 S. Ellwood Avenue 21224 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours attar dea Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural; or Items any Injury or other traumatic event, in Medical Examine 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 DYes 2 No WW2
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Truck Driver Brewerv 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surneme) George Edward Leader, Sr. Christina Hildebran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Shirley Leader 810 S. Ellwood Ave., Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount 5-15-00 Baltimore, MD 21. Signature & Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222 aczarous 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. It only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Atteroscherotic vascular Examiner bunial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be axed ettending physicien for use as the buriel P.O. Box 68760. Physician/Medical tha Due to (or as a consequen use as Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Records, Completed by 24b. Were autopsy findings available prior to thrive 24a. Was an autopsy completion of cause of death? has Renal Chronic 1 Yes 20 H 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical examiner?

1 Yas 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 After this funeral di To the Hospital or Attending Physicial States of the Within 24 hours efter death.

To the Funeral Director: After the Complately filled in by the funeral 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and titla of certific 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Linder Avenue, Bultimore MD 21201 827 32 Bogistrer's Signature

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31. Dete filed (Month, Day, Year)

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30. Name end address of person

31. Date filed (Month, Day, Yelf)

Marcos

Amora

2000

9000 Franklin Square Drive Battimore, MD 21237

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No amended item #7 per anatomy board g783 5/18/2000 ah 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Year **Physician** Nelaro 2000 13 erome 14 RTON /Medical 4b. City Town, or Location of Death 4c. County of Daath Facility Nama (If not institution, giva street and number) Examiner Bottom TUNAPOLIS)/d Undar 24 Hrs. If Under 1 Year Months Days 8. Data of Birth (Month, Day, Y. Dec 28, 9. Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** unle 78 Yrs 10 M 2□ F Hours PA 192-18-3769 Director Usual Rasidance of Decedant with the Meryland 10a. Stata 10b Counts 10c. City, Town or Location 10d. Inside City Limits ehow. "naturel", or items 23a or 28a-f ehoved call Examiner must be notified at MD Anne Arundel Annapolis 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 14. Race - American Indien, Funeral 68 Old Mill Bottom Rd #105 death 21401 13. Was Decedant of Hispanic Orlgin? (Spacify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever In U.S. Armed Forcas? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Improductant: If the marked other than "naturel; or file any Injury or other treumatic event, tra Medical Examines 1X Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 6 attorney domestic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be unk 2 Rose 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) James Giganti/nephew 20b. Placa of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☒ Othar (Specify) in stat in state 21. Signature of Funaral Service Licansae Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director nun 21201 Baltimore, MD art1. Entar the disage, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, Approximete Intervel Between Onset and Death **Physician** /Medical Immadiate Ceuse (Final disaasa or condition rasulting in death) Examiner Examiner eriosclevotic ettending physician end for use es the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initieted avants rasulting in daath) Last Due to (or as a consaquance of): P.O. Box 68760. Physician/Medical Due to (or es e consequença of) signed by the eld to be detected for 23b. Did tobacco usa contribute to the cause of death? Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Inknown Division of Vital Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? should should Completed is certificate has t director, page 2 s 2 L M8 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice stelly filled in by the funeral director. Be 25. Was casa rafarrad to madical 26. Placa of Daath (Chack only ona) axeminar? Othar: 4 ☐ Nursing Homa 5 ☐ Aasidanca 6 ☐ Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 1 Neturel 5 Pending invastigation 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Straat end Number or Rural Routa Numbar, City or Town, Stata) 28a. Placa of Injury - At home, farm, straet, fectory, office building, atc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To tha best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the tima, data and piaca, end due to the causa(s) and mennar stated. To the Hospi within 24 hou To the Funer completely fil 29a. Cartifian edical

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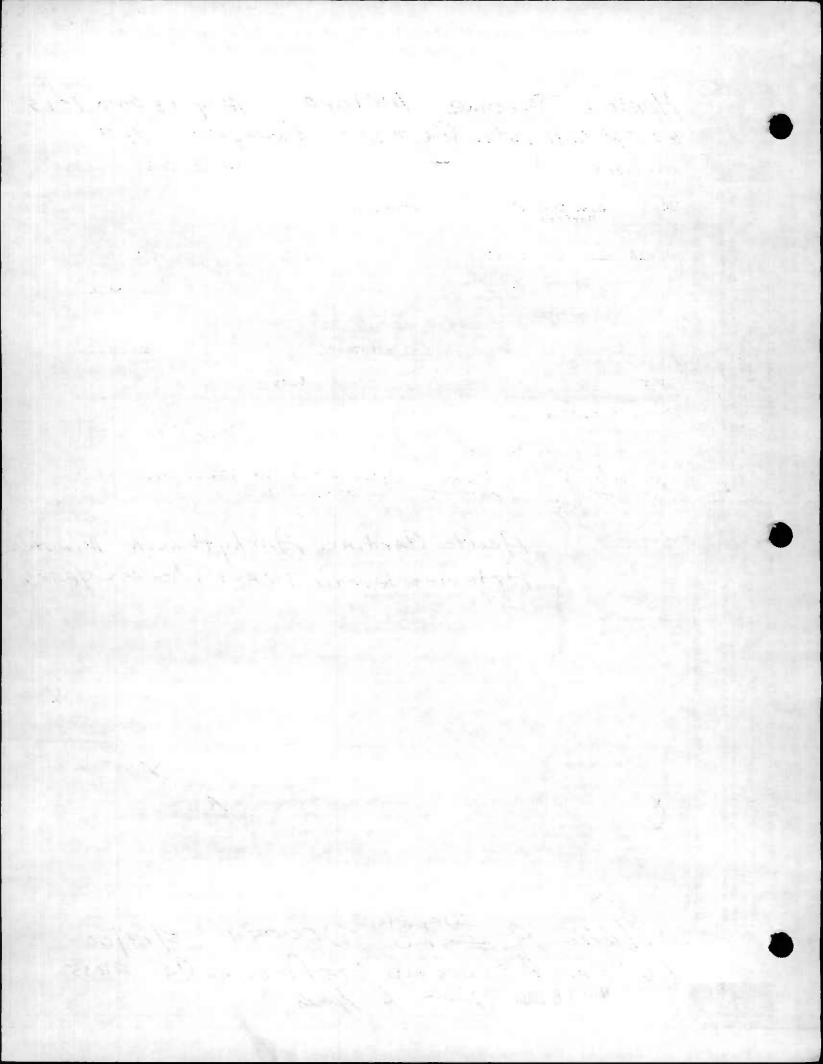
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32. Registrar's Signetura

iss of person who completed payse of death (Itam 23a) (Type, Print)

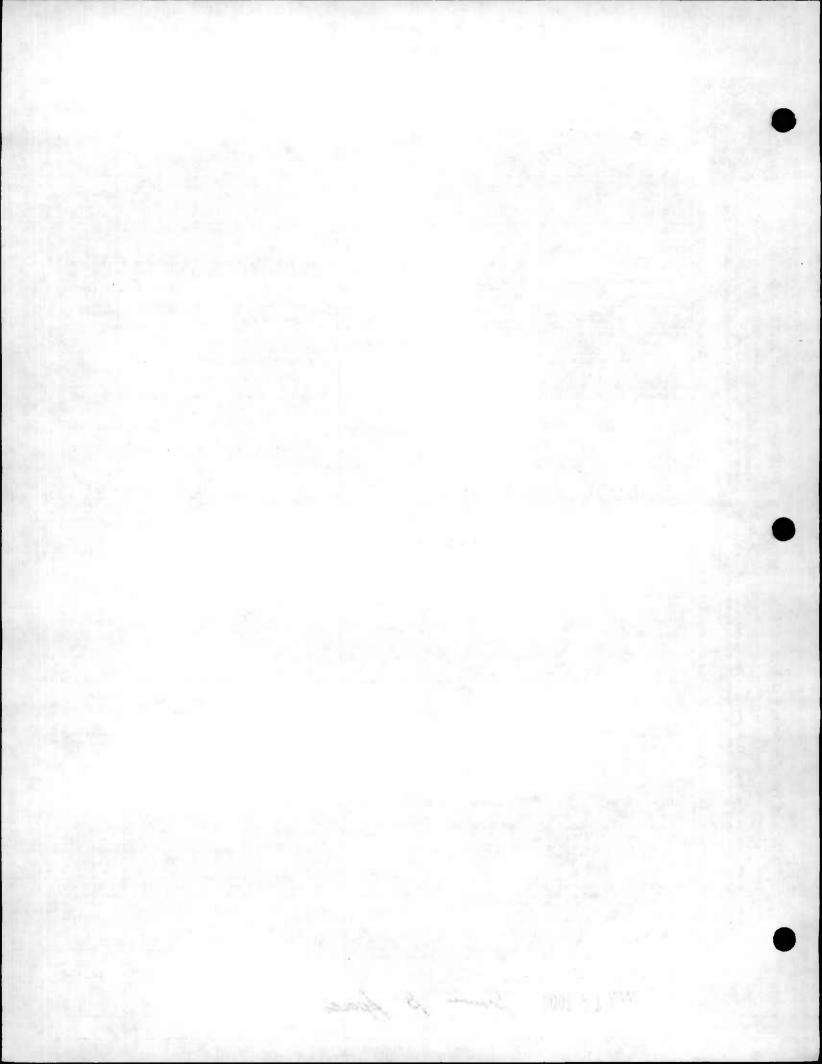
29d. Data signed (Month, Dev. Year)

State Registrar 29b. Signature and titla of certifiar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Year **Physician** Leila McNeal 4b. City, Town, or Location of Death 17, 2000 4c. County of Death 12:04 pm /Medical 4a Fecility Nama (If not Institution, giva street end number) Examiner 242 North Marlyn Avenue Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Aug. 6, 1916 6. Sax Birthplaca (Stata or Foreign Country) 7. Aga (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 12 F 83 Yrs. Aug. 219 01 6948 Director Virginia Usuel Residence of Decedant 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ma 23e or 242 North Marlyn Avenue 21221 USA Funeral 12. Was Decedent Evar in U,S.
Armed Forcas?
1 ☐ Yas 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. ** natural*, or Itan any injury or other traumatic event, the Medical Examinations. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Vas 2 No Specify If Yas Giva À 3 X Widowed 4 □ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) (Giva kind of work done during most of working lifa. DO NOT use retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 Housewife Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) e Mary Jane Walley Elick M. Powell 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Alfred Brennan (Personal Rep.) 825 Eastern Avenue Essex, Md. 21221 20b. Ptace of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramovat from State Holly Hill Mem. Gardens 5/20/2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Durkous Approximata Intervet Between Onset and Death 23a Farth. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final diseasa or condition resulting in daath) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata cause. Entar Undarlying Ceuse (Disease or Injury Dua to (or as a consequenca of) Box 68760. thet initiated avents rasulting In daath) Last Dua to (or as a consequence of) signed by the aid of be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed page 2 should 24a. Was en autopsy 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No After this certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director. Be 25. Was casa retarred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Rasidence 6 Other (Specify) Certification: To 1 Yes 2€ No funeral 27. Mennar of Death 28e. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant filled in by the 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 I Homicida 24 hours edical 1 Certifying Physician: To the best of my knowledga, death occurred et the time, data and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completely fil 29a. Certifian ž 29b. Signatura and fitla of certified 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) Castern Avenue Bult. MD 21224 MD 4940 K00, 32. Pegistrer's Signetura State 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last)

RUTH E. MORROW

4a Facility Name (If not institution, give street and number)

LORIEN NURSING AT RIVERSIDE

5. Social Security Number

6. Sex

215-32-6823

1 M 2MF

7. Age (In yrs. last birthday)

91 Yrs.

Months Days Hours Min.

Month Days Hours Min.

Month, Day, Year)

Month, Day, Year)

Dec 23, 1908

9. Birthplace (Stete or Foreign Country)

MD

Usual Residence of Decedent

10c. City, Town or Location

Aberdeen

1 Oc. City, Town or Location

Aberdeen

Baitimore, Maryland 21215-0020
pemit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mentel Hyglene. Important: If hem 27 is marked other than "retural", or hems 23e or 28e1 ahow any injury or other traumatic event, the Hedical Examinat he notified at abotics.

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be associted within 24 hours after deeth.

To the Funeral Director: After this cartificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

215-32-6													M	
Usual Residence 10a. State	of Decedent		10c Ci	ty Town	or Location								10d look	do City Limite
														de City Limits Yes 2X No
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10e. Street and N	lumber				10f. Zi	ip Code				10g. Citi			intry?	
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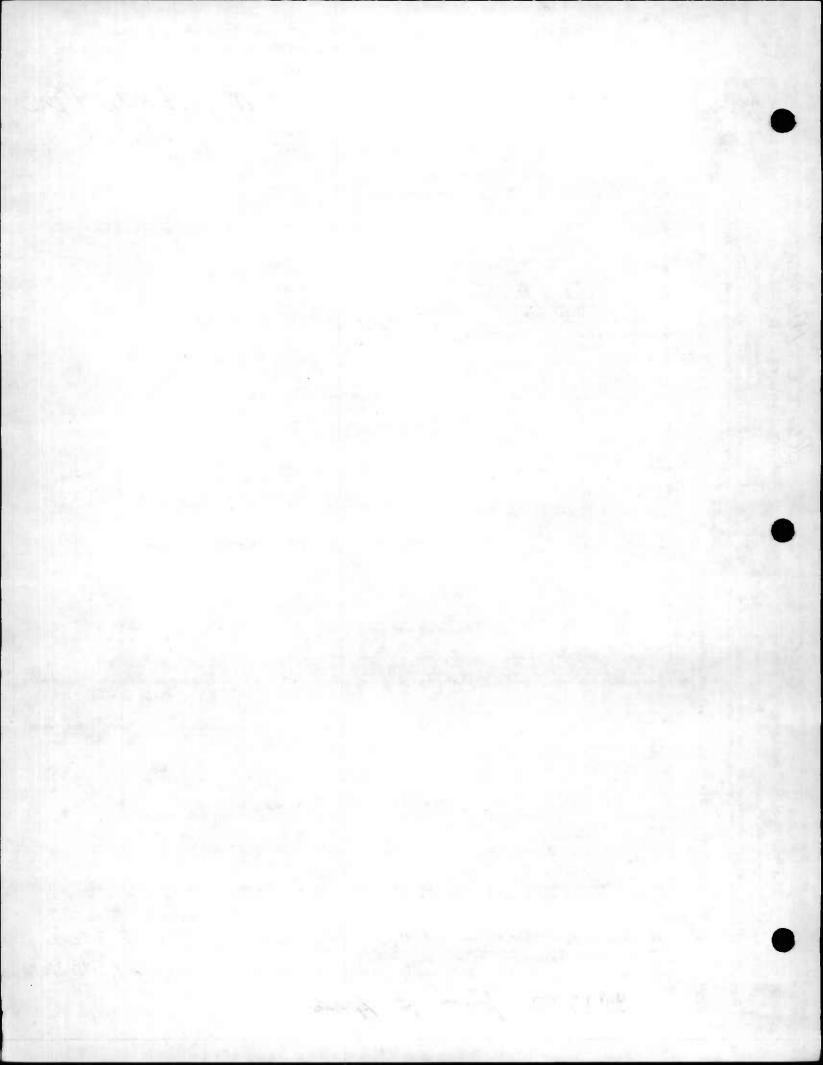
State

Registrar

31. Date filed (Month, Day, Year) MAY 1 8

Sporks

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#30 PER MD. G783 5-18-2000 JAB Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month Day **Physician** Philip Miller May 10, 2000 12:00 AM /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 M 2 □ F Yrs. 87 214 20 8786 Director Sept. 30, 1912 Maryland Usuel Rasidence of Decedant death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow tem 27 is marked other than "natural", or flams 23s or 28s-f sho other treumstic event, the Medical Examinar must be notified as 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? United States 1337 Swan Dr. Funeral 21401 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yes, Give 1 Never Married 2 Married 21215-0020 1 Yas 2 No Specity: þ Specify: White 3 kg Widowed 4 □ Divorced Yaar or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stone Mason Construction 9 altimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ia marked oth any Injury or other treumatic event Be Elizabeth K. Woodiger Danie1 F. 2 Miller 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Margery S. LaMar / Attorney 150 South St. Suite #105, Annapolis, MD 21401 20b. Place of Disposition (Nama of cametary, crematory or other placa) 20e. Mathod of Disposition May 11, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory Inc. 2000 Beltsville, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286 Approximate Interval Between Onset and Death **Physician** WIDELY METASTATIC BRADDER. /Medical Immediata Ceuse (Final disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or injury that initiated events resulting in death) Last and Due to (or as a consequenca of): Box 68760. Physician/Medical the Due to (or as a consequenca of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24e. Was en eutopsy performed? Completed 24b. Wera autopsy findings available prior to completion of causa of deeth? page 2 certificate has of Vital Physicien: 25. Was casa rafarred to madical examinar? Be 26. Placa of Daath (Check only ona) spital: 1 Inpatient 2[28a. Date of Injury (Month, Day Year) examinar? Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attanding 1 ANatural 5 Panding investigation s after death.

I Director: After the by the further. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by datermined 4 Homlcida within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and place, end due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end mannar stated. 29a. Certifier completely (Check only one) 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certified Gene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEYIN J. OKEFFE

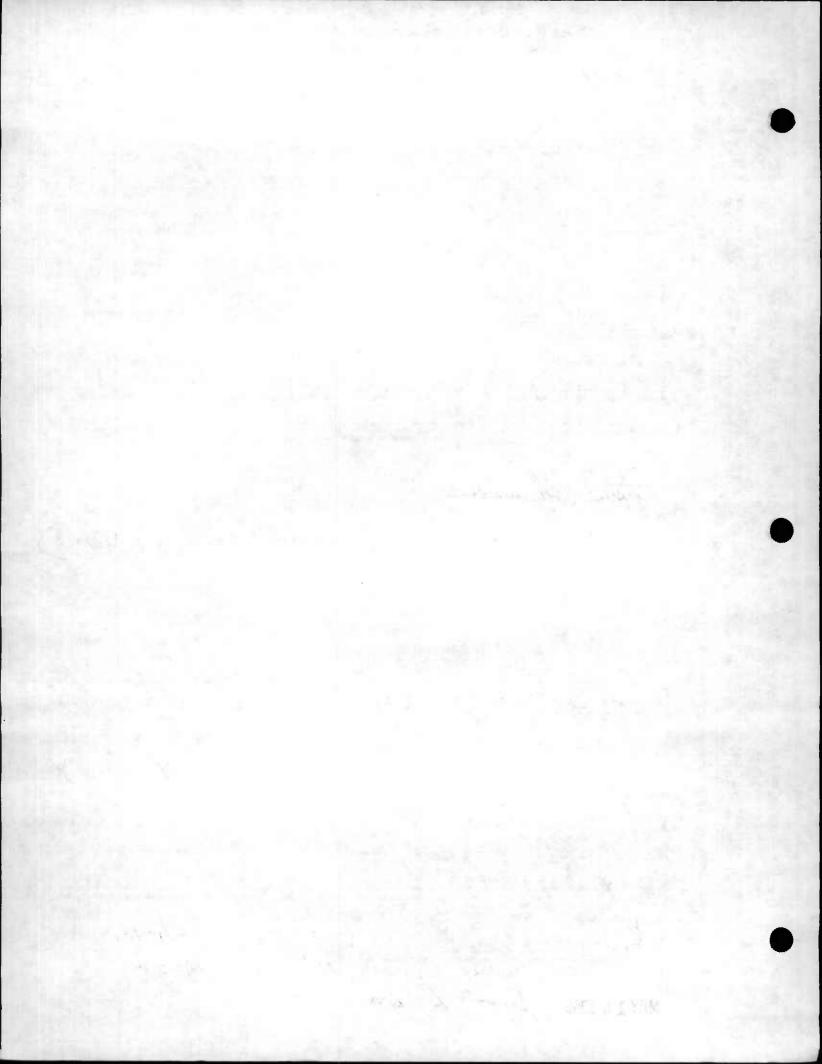
OF TERMS HICHMY SUITE III MILLERSYILLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

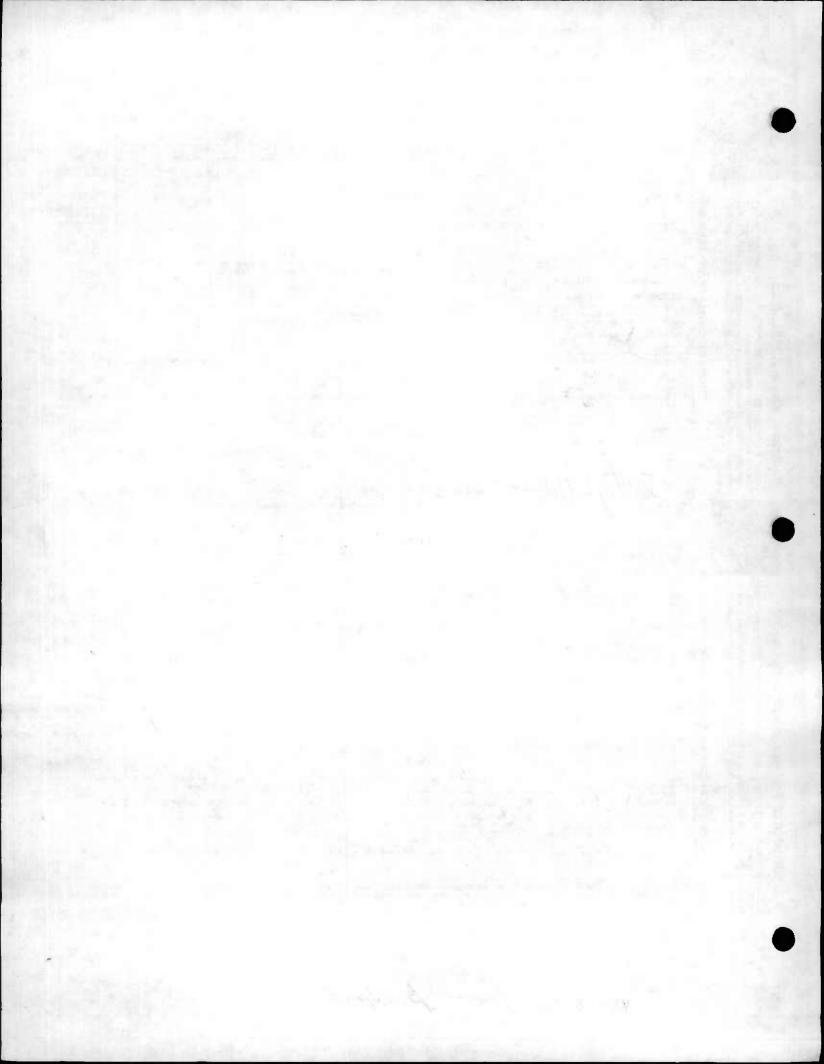
MAY 1 8 2000



State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death			Reg. No.			
	Decedent's Name (First, Middle, Last)								alh Dey	Yeer	3. Time of Death	
Physician	Henjamin Orville Mellor Ir							12:55 a.m.				
/Medical Examiner	de Feelle, Name (Mant Institution plus street and combant						wn, or Lo	cation of Deat	16, 2000 4c. County	of Death	12.00 4.111.	
LXAITIILIE	A Thomas and the	0040 Oaadlass	t-1, O4				Sykesy	illo		Corr	oll	
Funeral	5. Social Security Number	6316 Candlew	7. Age (In yrs. last b	oirthday) If Unde	r 1 Year			8. Date of Bir (Month, Da	th	9. Birtho		
Director	040.00.0450	10 M 20 F	79	Yrs. Months Days Hours Min.			Min.					
5	213-09-6152 X /9 Usual Residence of Decedent							May 19, 1920 M			RYLAND	
E Bu	10a. State 10b. County 10c. City, Town or Location							100		1	10d. Inside City Limits	
Man Man	Maryland Carroll Sykesville										1 ☐ Yes _X 2 ☐ No	
vith the Ma or 28a-f e be notified Director	10e. Street and Number	Carroll		101. Zi	p Code	resyllie			10g. Citizen of	Whel Cour	niry?	
	6316 Candlewick Co	ourt				2178	4			U.S.A.		
her death in the same same same same same same same sam	11. Marital Stalus	12. Wes Dece	ident Ever in U,S.	13. Was Dece	dent of H	lispanic Ori	igin? (Spe	city Yes or No	- 14. Rad		can Indien,	
	1 Never Married 2 Me	erried t ☐ Yes	Armed Forces? If Yes, specify Cult			an, Mexica	n, Puerto I	Rican, etc.)	Bla	Black, White, etc.		
ar, or	3 ☐ Widowed 4 ☐ Divorce	ed Year or Da	e ates:	1 ☐ Yes	X2□ No	Specify:			Specif	y: W	/hite	
72 hours shar natural, or its sted Examina sted by Fu	15. Decede	ent's Education	166	a. Decedent's Use	al Occup	ation			16b. Kind of B	usiness/In	dustry	
ed within 72 ho ygiene. wer than "metur it, the Medical. Completed		hest grade completed)	(5.)	(Give kind of w life. DO NOT	ork done i ise retired	during mos d)	it of worki	ng			1 1	
i within fere. The Men	Elementary/Secondary (0-12	College (1	-40r 5+)		Sund	ervisor				Railroa	ad	
Hilled Hygger Hygger C ent.	17. Father's Name (First, Middle	le, Last)			Supe		er's Neme	(First, Middle	Maiden Sumar	ne)		
d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Exam. To Be Completed by !	Poniomin	Orville Mellor.	Cr.					Carr	ie M. Livelv			
M br	19a. Informent's Name/Relatio			b. Mailing Addres	s (Street	and Numb	er or Rum				Code)	
796												
9884	20a. Method of Disposition	aron L. Nelson_		of Disposition (Na	me of	13	Sykes	Dete Dete	land 21784		own. Siele	
semit. Pages 1 s. Jegariment of Hes reportant: if Item my injury or othe RIGS.	1 Burial 2 ☐ Cremetion		State cemet	ery, crematory or	other plac	De)						
d day	4 □ Donation 5 □ Other		Go	od Shepher				5/19/00	Ellicott	City, N	Maryland	
and and and and and and and and and and	21. Signature of Fundral Service	ce Licensee		22. Name a								
	YULUH UVS	1100-	MOH13			neral H Colum			City, MD 21	043		
	23a. Pert1. Enter the disease, shock, or heart trillure. Li	complications that o	eused the death. Do								Approximete Intervel Between	
Physician				^							Onsel end Deeth	
/Medical	Immediate Cause (Final disease or condition	1.71	OPATH	10 11	m	MARI	RY.	+1B6	21209	1	11) URP	
Examiner	resulting in death)	a. D. Wi		consequence of		,,,,,	-	1 1101	w 1.3	1	10 //9	
<u> </u>			500 10 (01 63 8	consequence of						1		
cate be assected physician and s the buriel-transit	Convention list and distance	b	Due to for se s	consequence of						1	•	
Exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ns, Due to (or as a consequence of):										
artificate be associated sing physician and sees the buriel-transit	Cause (Disease or injury that initiated events	Due to fee on a										
ficati phy s th	resulting in death) Last	Due to (or as a consequence of):										
oentif ding		d										
death o												
as that the death certific grad by the attending p be deteched for use as by Physician/Me	Part II. Other significant condit	tions contributing to de	contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribut			A STATE OF THE STA	
thet the ded by dete								10	Yes 2 No	3 Pro	bably 4 Unknow	
signe 1 be d								04-144		245 16	fore autonou findings	
The law requires tate has been sign page 2 should be Completed by									en eulopsy ormed?	ev	fere eutopsy findings vailable prior to empletion of cause	
law 2 al										of	deelh?	
								10	Yes 2 No	11	☐Yes 2☐No	
certificate irector, per	25. Wes cese referred to medic	cal				26. Place	e of Deeth	(Check only	one)	1		
	examiner?	Hospital: 1 🗆 I	npatient 2 ER/C	Outpatient 3 D	OA Oth	or-			dence 6 □Otl	her (Speci	(v)	
Physical d	27. Manner of Death	28a. Date o	of Injury 28b.	Time of	28c. Injur Wor				how Injury occu		**	
ding the transfer	1 Natural 5 Pend 2 Accident inves	ding (Mont stigation	h, Day Year)	Injury M		k/ Yes 2□	No					
at or Attending P is effect death. In Director: After the funer of in by the funer Certification:	3 ☐ Suicide 6 ☐ Coul	d not be mined 28e. Place	of Injury - At home, f	ferm, street, fecto	ry, office		- 1			ber or Rur	al Route Number,	
Direction A	4 Homicide		28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					City or To	wn, State)			
Tana a	29a. Certifier 1 ☐ Certify	dag Physiolog: To the	hast of my knowledg	no double converse	Lat the tie	no doto os	d plane a	and due to the	councile) and m	00001001	alolod	
To the Hospitat or I within 24 hours effer To the Funeral Dire completely filled in E Medical Certi		ring Physician: To the al Examiner: On the ba	sis of examinetion a									
thin 2 the omple	29b. Signature and title of certif	and manr	NOT SIZIOU.	20	c Licene	e number		1	29d. Date signe	ad /Manth	Day Year!	
F3F8	1 000	1 1	112	7) T		211		C 1 -		Cay, 10ai)	
1	NICC	MIL		- 2) ~	92	TO		2/1	110		
M	30. Name and address of person								7			
CAR	N. Rajpara, M.D. 2	17 Washington I	Hts. Westmin	ster, MD 21	157							
State	31. Dale filed (Month, Day, Yea	32.	egistrar's Signature	4 /	nes	/						
Registrar	MAY 1 8	2000	1	. popor	no							

DHMH 16 Rev 6/95

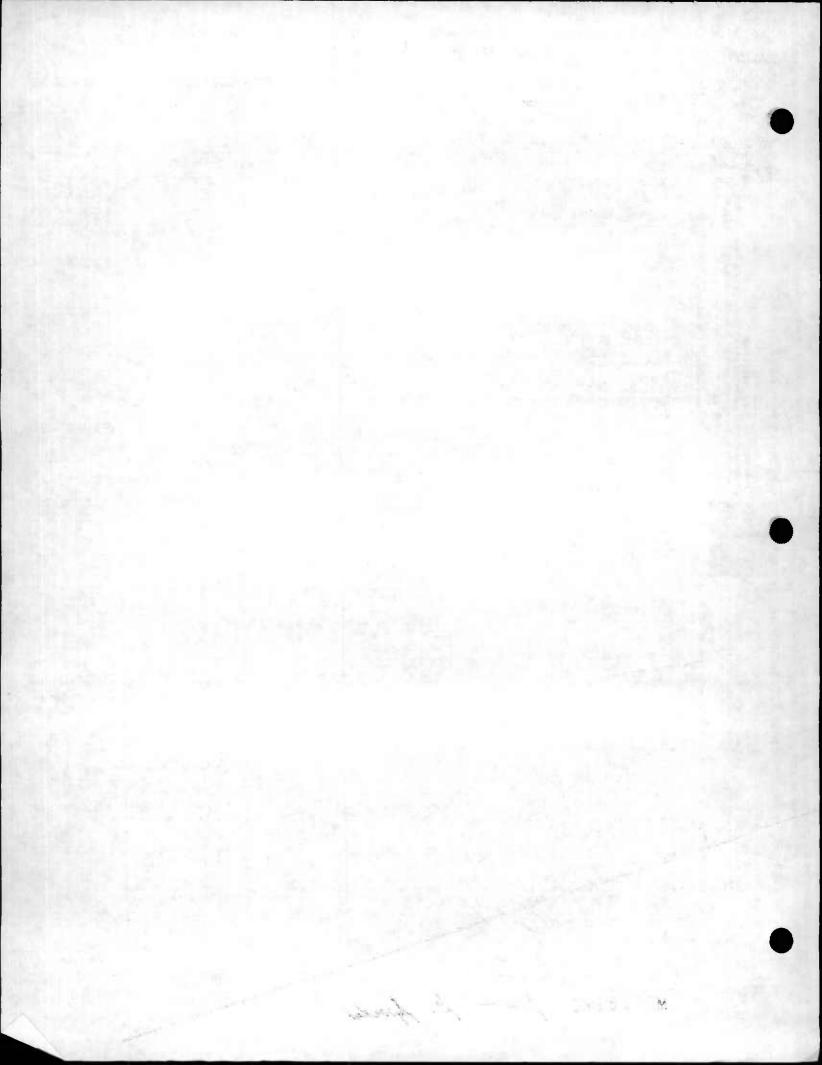


State of Maryland / Department

of Health and Mental Hygiene	10	5	9	6	
of Dooth		40	-		

			Cert	ificate of	Death		Reg. No.				
	1. Decedant's Name (First, Middle,	Last)	2. Date of Do		3. Time of Death						
Physician	RONALD LEE	Month	10 2	2000 6:56 A.I							
/Medical Examiner	4a Facility Name (If not Institution,	McCAULEY, III give street and number)		1	4b. City, Town, o	r Location of Dear		,			
Examiner	218 North Belno	ord Avenue			Baltin	nore	l N	I/A			
Funeral		6. Sex 7. Age (In yrs	rs. 8 Date of Bi	rth	Birthplace (Stata or Fore Country)						
Director	220-11-0012	10XM 2□F 14		Months Days	Hours Mi	n. (Month, D	pt. 28,1985 MARYLAND				
72 hours after death with the Maryland natural', or flams 23a or 28a-f show odes Examiner must be notified at eted by Funeral Director	Usual Residence of Decedent	10000	20,1300	THATTERINE							
	10a. State 10b. County	10c. C			10d. Inside City Lim						
	MD.	N/A B			1 N Yes 2 □!						
	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?			
S T D	218 N. Belnord	Avanua	nue 21224					٨			
r hams 234 siner must Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	(Specify Yes or N		- Amarican Indian,						
or to	Never Married 2 Marrie	erto Rican, etc.)	Blac	k, White, etc.							
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	☐ Yes XX No	Specify:		Specify: WHITE				
or than "netural", 1, the Messical Earl Completed by	15. Decedent's	Education	16a. Decede	ent's Usual Occup		16b. Kind of Bu	sinass/Industry				
Die n	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	- (Give k	ind of work dona of NOT use retired	dunng most of w d)	orking	ng				
Hygiene. ther then and, the Me	8	College (1-401 54)	STU	DENT			N/A				
Tes a	17. Father's Name (First, Middle, La	ast)	74.11.743		18. Mother's N	ame (First, Middle	, Maidan Sumam	a)			
ked o	RONALD L. McCA	III FY . JR .			MARY	J. LATTA					
end Mentel marked o numatic ava	19a. Informant's Name/Relationshi		19b. Mailing	Address (Street			per, City or Town,	State, Zip Code)			
5/5	MARY J. LATTA/ I	MOTHER	218 N	RELNOD	D AVENU	RAITIM	ORE, MARY	AND 21224			
155	20a. Method of Disposition		Place of Dispos	ition (Name of	74	Date		City or Town, State			
0	1 🛱 Burial 2 □ Cramation 3		11.00	atory or other place		T /1 0 /00					
	4 Donation 5 Other (Spe			ART OF J		5/19/00	BALITMU	RE, MARYLAND			
Departr Importu any initianones once	21. Signature of Funeral Service Li	censee	LI	Name and Addre	ILER IN	C. FUNER	AL HOME				
0200	Continue	B SLEWIN						MARYLAND 2122			
	23a. Part1. Entar the disease, or coshock, or heart tailura. List or	omplications that caused the dea						Approximate Interval Between			
Medical xaminer	tmmediata Causa (Final disease or condition resulting in death)	a. <u>Narcotic ir</u> Dua to	ntoxicat (or as a consaqu								
physician end s the burial-transit edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
ding physician end se as the burlal-transit /// Adicai Examir	Cause (Disease or Injury that initiated events resulting in death) Last	CDua to (ence of):								
for us	Part II. Other significant condition	a contributing to death but not re	23b. Did tobacco use contribute to the cause of								
ed by the detached					10	1 Yes 2 No 3 Pro					
E 2					Alta.		s an autopsy ormed?	24b. Wara autopsy finding available prior to completion of cause of death?			
as p						De	Yes 2□ No	A Pes 2□ No			
has ge 2					26. Place of D	eath (Check only	one)	,			
page 2	25. Was case refarred to medical		ER/Outpatient	3□ DOA Oth	oer.			ar (Specify)			
page 2	25. Was case refarred to medical examiner? 1X Yes 2 No	Hospital: 1 Inpatient 2				-		sidance 6 Other (Specify) how injury occurred			
his certificate has al director, page 2 To Be Comp	examiner? 1%∑ Yes 2 No 27. Manner of Death	28a. Data of Injury	28b. Tima of	200. 11.00			Unknown				
his certificate has al director, page 2 To Be Comp	examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Panding	28a. Data of Injury (Month, Day Year)	Injury	28c. Injur Wor 1 □	rk? Yas 2√∑No	Unkr	own				
his certificate has al director, page 2 To Be Comp	examiner? 1%2 Yes 2 No 27. Manner of Death 1 Natural 5 Panding 2 Accident investiga 3 Suicide	28a. Data of Injury (Month, Day Year)	Unknow	vrM 10		28f. Location	(Street and Numb	er or Rural Route Number,			
ler death. rector: After this certificate has n by the funeral director, page 2 tification: To Be Comp	examiner? 1½ Yes 2 No 27. Manner of Death 1 Natural 5 Panding 2 Accident investiga	28a. Place of Injury (Month, Day Year) of be led 28a. Place of Injury - At building, atc. (Spec	Injury Unknow homa, farm, stree ify)	vrM 10		28f. Location	(Street and Numb				
ler death. rector: After this certificate has n by the funeral director, page 2 tification: To Be Comp	examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check Check	28a. Data of Injury (Month, Day Year) attion Tound: 5-10-0 28a. Place of Injury - At building, atc. (Spec Found in hol	Unknown of the street of the s	et, factory, offica	Yas 2√√ No	28f. Location City or To 218 N.	(Street and Numbown, State) Belnord cause(s) and ma	Ave.,Baltimor			
ler death. rector: After this certificate has n by the funeral director, page 2 tification: To Be Comp	examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investiga 3 Suicide 6 Could no datarmin 29a. Certifier 1 Certifying (Check one) 2 Medical Examples	28a. Place of Injury Attended to be led 28a. Place of Injury Attended 28a. Place of Injury Attended 28a. Place of Injury Attended 28a. Place of Injury Attended 28a. Place of Injury Attended 28a. Place of Injury Attended 2	Unknown of the street of the s	occurred at tha tirestigation, in my o	Ma, data and pla	28f. Location City or To 218 N.	(Street and Numbown, State) Belnord a cause(s) and ma, data and placa, s	Ave., Baltimor nner as stated.D and due to the cause(s)			
rs after death. In Director: After this certificate has led in by the funeral director, page 2 Certification: To Be Comp	examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check Check	28a. Data of Injury (Month, Day Year) attion Tound: 5-10-0 28a. Place of Injury - At building, atc. (Spec Found in hol	Unknown of the street of the s	occurred at tha tirestigation, in my o	Mas 2 No	28f. Location City or To 218 N. ca, and dua to the courred at tha time	(Street and Numbown, State) BeInord I cause(s) and ma, data and place, a	Ave., Baltimor nner as stated.D and due to the cause(s) d (Month, Day, Year)			
ler death. rector: After this certificate has n by the funeral director, page 2 tification: To Be Comp	examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investiga 3 Suicide 6 Could no datarmin 29a. Certifier 1 Certifying (Check one) 2 Medical Examples	28a. Data of Injury (Month, Day Year) attion Tound: 5-10-0 28a. Place of Injury - At building, atc. (Spec Found in hol	Unknown of the street of the s	occurred at tha tirestigation, in my o	Ma, data and pla	28f. Location City or To 218 N. ca, and dua to the courred at tha time	(Street and Numbown, State) Belnord a cause(s) and ma, data and placa, s	Ave., Baltimor nner as stated.D and due to the cause(s) d (Month, Day, Year)			
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ler death. rector: After this certificate has n by the funeral director, page 2 tification: To Be Comp	examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Panding investiga 3 Suicide 4 Homicide 29a. Certifier 1 Certifying (Check one) 2 Medical Example 2	28a. Place of Injury (Month, Day Year) atton Tound: 5-10-0 28a. Place of Injury - Att building, atc. (Spec Found in hot Physician: To the best of my kn xaminer: On the basis of examinand mannar stated.	Unknown streethy) Unknown streethy) owledga, death ation and/or investment 23a) (Type, P	et, factory, offica occurred at tha tir settigation, in my o	Ma, data and pla popinion, death oc se number O.C.M.E	28f. Location City or To 218 N.	(Street and Numbown, State) Be Inord a cause(s) and ma, data and placa, a 29d. Date signed May 11,	Ave., Baltimor nner as stated.D and due to the cause(s) d (Month, Day, Year)			

	to Facility Name (Mant leathstion also street and sumbers)							2. Dete of Deetl Month	Dey	Yeer	Time of Deeth
/Medical							4b. City, Town, or	MAY Location of Death	12, 20 4c. County		:42P.M.
Examiner		722 GOUGH STREE				BALTIMO	RE	N/			
uneral rector		5. Social Security Number 6. Sex 219-82-4177 6. Sex 1 Months Deys Hours							Year) , 1975	9. Birthplece Country) Mary La	(State or Foreig
thygiene. ther than *natural*, or items 23s or 28s-f show ont, the Modical Exercine; must be notified at \$ Completed by Funeral Director	10	suel Residence of Decedent Da. State 10b. County MD	N/A	<u> </u>	y, Town or Lo	cation				nside City Limit	
r tems 23s or 25s-fs dref. Pust be notified Funeral Director	10	De. Street and Number 1722 Gough Stree	+			10f. Zlp Cod 2123		10	Whet Country?		
ma 23	111	, Menitel Status	12. Wes Deceden	t Ever in U,	S. 13. V			Specify Yes or No-	USA 14. Rac	a - American In	dien,
item 27 is marked other than "natural", or item other traumatic event, the Medical Examinat. To Be Completed by Fun	•	11. Mentel Status 1 □ Never Merried 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, specify Cuben, Mexican, P 1 □ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify:						rto Rican, etc.)	Specify	ck, White, etc. v: White	
		15. Decedent's (Specify only highest s Etementery/Secondary (0-12)	Education rade completed) College (1-4or	5+)	(Give life. L		cupation ne during most of w ired)	orking		usiness/Industry	
		10 Waitress 17. Fether's Neme (First, Middle, Last) Waitress						me (First, Middle, A	me (First, Middle, Maiden Surneme)		
		Joseph G. Osbor					Marie E				
e me		9e. Informent's Neme/Relationship	(Type, Print)		19b. Maitin	g Address (Str	eet and Number or F	Rurel Route Number,	, City or Town,	Stete, Zip Cod	в)
Important: If tem 27 is ma any injury or other traums once.		Joe Osborne		20h D	326 F	UTTOW Sition (Name of	St., Balt:	more, Md.		City or Town,	State
	20	De. Method of Disposition 1 D Burial 2 Cremetion 3		0	emetery, cren	netory or other	olece)	5/10/			51616
	2	4 ☐ Donetion 5 ☐ Other (Special Special Service Licenses)					igton Crm	13/00	Laure	1, Md.	
	21. Signeture of Funerei Service Licensee **Market Molust** 22. Name end Address of Fecility Gary L. Kaufman Funera 7250 Washington Blvd.,										e MP, Ir 075
edic	re	shock, or heert teiture. List on nmediate Cause (Final iseese or condition ssulting in deeth)		OTIC	AND AL		NTOXICATI	ON		Ons	rval Between let and Death
			h .								
physicia s the bur edical	Chh	equentially list conditions, any, teeding to immediate ause. Enter Underlying ause (Disease or Injury act initiated events soutling in death) Lest	b		r es e conseq r es e conseq						
attending physicia for use as the bur clan/Medical	Chh	iet inneted events soutting in death) Lest	cd	Due to (or	r es e conseq	uenca of):	given in Pert I.	23b. Did to	becco uas co	ntributs to the	cause of deat
by the attending physicis teched for use as the bur teched for use as the bur hysiclan/Medical	Chhre	et initieted events	cdcontributing to death	Due to (or	r es e conseq	uenca of):	given in Pert I.		becco uas co as 2□ No	ntributs to the	
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has been signed by the attending physicia je 2 should be deteched for use as the but mpleted by Physiclan/Medical	C th	iet inneted events soutting in death) Lest	b	Due to (or	r es e conseq	uenca of):	given in Pert I.	1 ☐ Ye	n autopsy ned?	3 Probably 24b. Were a evailable comple	utopsy findings be prior to tion of ceuse
ate has been signed by the attending physicia page 2 should be deteched for use es the bur page 2 should be deteched for use es the bur page 2 should by Physiclan/Medical	Pe	ent illicated events southing in death) Lest ent II. Other significant conditions to the conditions of		Due to (or	r es e conseq	uenca of): nderlying cause	26. Place of D	1 TY	n autopsy ned?	3 Probably 24b. Were a evailable comple of death	utopsy findings be prior to tion of ceuse
is cardificate has been signed by the attending physicia director, page 2 should be deleched for use es the bur director, page 2 should by Physiclan/Medical	Pe	ent illicated events soluting in death) Lest ent II. Other significant conditions of the conditions of	Hospitel: 1 ☐ Inpet	Due to (or	r es e consequent es e consequ	uenca of): inderlying cause	26. Place of D Other: 4 ☐ Nursing	1 ☐ Ye 24a. Wes all perform 1 ☐ Ye seth (Check only on the character)	n autopsy med?	3 ☐ Probably 24b. Were a evailable comple of death 1 ☐ Yer	utopsy finding: be prior to tion of ceuse
is cardificate has been signed by the attending physicia director, page 2 should be deleched for use es the bur director, page 2 should by Physiclan/Medical	Pe	ent illicated events southing in death) Lest et ill. Other significant conditions in illicate conditions in illica	Hospitel: 1 Inpat	Due to (or	es e consequenting in the understanding in the unde	uenca of): nderlying cause t 3□ DOA P 28c. I(26. Place of D	24a. Wes ai perform 1 Ve 24h. Check only on Home SAReside 28d. Describe ho	n autopsy med?	3 ☐ Probably 24b. Were a evailable comple of death 1 ☐ Yer	utopsy findings be prior to tion of ceuse
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his certificate has been signed by the attending physicia idirectior, page 2 should be deteched for use as the but I directior, page 2 should be deteched for use as the but I De Be Completed by Physician/Medical	25 27 25 25 25 27	5. Was case referred to medical examiner? 1. Neturel 5 Pending investiget 2 Accident 3 Suicide 4 Homlcide 9a. Certifler (Check only 2 Medical Ex	Hospitel: 1 Inpet 28e Dete of In FOUND: 5-12-0 28e Plece of Ir building. FO Physician: To the bes	but not resident 2 ury ay Year) O Uite. (Specific UND A' tof my know to form)	ER/Outpetien 28b. Time of FOUND: 2;00 TRESI wledge, death	t 3 DOA P 28c. In DENCE	26. Place of D. Other: 4 Nursing njury at Nork? Yes 2 10 No	24a. Wes an perform 1 Veseth (Check only on Home 3 Reside 28d. Describe how UNK 28f. Location (St. BALTIM) 2e, and due to the capured et the time, date	n autopsy med? ss 2 No e) snce 6 Oth w injury occur NOWN rest and Number is State, Manager ause(s) and manager aute and place,	3 Probably 24b. Were a evallable comple of death 162 Yell of the complete of	utopsy finding le prior to tion of ceuse ? s 2 No



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07 Day Month 05 **Physician** Theresa Ozarowski 2000 7:30 am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Lakeside Manor Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 10-21-1917 5. Social Security Number Birthpleca (State or Foreign MD MD) 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 217 F 213-09-5283 Yrs **Director** Usual Residence of Decedent 10e, State 10b. County 10c. City. Town or Location 10d. fnside City Limits na 23a or 28a-f shor Nas 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 Elrino Street 21224 USA Funeral Hems 2 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status illed within 72 hours after 1 Tas 2 No If Yes, Give Yeer or Dates: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 21215-0020 White 5 Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Home permit. Peges 1 and 2 should be file Department of Health and Mentel Hyy Important: If Item 27 is marked othe any injury or other traumatic event, phose. Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) UNKNOWN UNKNOWN 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Anthony Ozarowski 8223 Dorset Avenue, Baltimore, MD 21237 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State Holy Rosary Cemetery 5-11-2000 Baltimore, MD 11222 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue, Baltimore, MD 21222 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximala Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical ATharo Scheoter Vascular Disease Examiner Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to for as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown his myraclin Infant, his pepter when disease, Records, 2 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Be Completed 24a. Was an autopsy 1 Yes 2 No certificate 1 Yes 2 No Division of Vital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident within 24 hours after deet To the Funeral Director: 6 Could not ba determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signatura and title of certifian 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANK ST BALTO, Med LIBERTO, MD. 3008

DHMH 16 Rev 6/95

Registrar

32. Registrar's Signatu



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Dey 2000 Month MAY 8:55am HENRY JOSEPH RISTON SR. 14 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, giva street end number) 4c. County of Deeth Baltimore Essex 329 Torner Road If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foraign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Hours Deys 1₽M 2□F Months 71 220-24-4392 Oct. 19 1928 Maryland Maryland Usuel Residenca of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex 1 ☐ Yes 2 No MD 10f. Zip Code 10o. Citizen of What Country? 10e Street and Number 21221 USA 329 Torner Road Wes Decedent of Hispanic Orlgin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decadent Evar in U,S. Armed Forces? 11. Marital Status 1 1 Yes 2 □ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Beth Steel 6th Sheet Metal Shop 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Agnes M Reck Joseph W Riston 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 9206 Ramblebrook Road Baltimore Md. 21236 Henry J. Riston Jr. /son 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata Date 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetlon 5 □ Other (Specify) 5/18/2000 Baltimore Md. Loudon Park Cemetery 21. Signeture of Funeral Service Licenses 22. Nama end Address of Facility Connelly Funeral Home of Essex Onn 300 Mace Ave. Baltimore Md. 21221 23a. Pert1. Enter the disease, or complications that caused the death / Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final month obstruction nach disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence ol): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy lindings eveilable prior to 24e. Wes en autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

The law requires

has

this

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

show

r than "naturel", or items 23s or 28a-f show

with the Maryland

Pages 1 and 2 should be filed within 72 hours aftar nant of Haalth and Mental Hygiena.

I Hygiena.

permit. Pages 1 and 2 should by Department of Haath and Merta Important: If item 27 is marked eny injury or other traumatic events.

is marked

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit funaral

Physician/Medical þ Completed Be edical Certification: To

25. Wes case referred to medical 27. Menner of Death

1□ Yes 2⊡ No

5 Pending investigation

6 ☐ Could not be

T'8

Brave

31. Dete filed (Mont) MAY

1 Netural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

USB page 2 s

To the Hospital or Attanding PI within 24 hours after death.
To the Funeral Director: After the complately filled in by the funeral

DHMH 16 Rev 6/95

State Registrar

29b. Signature and title of certified

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Pleca of Injury - At home, larm, street, fectory, office building, etc. (Specify)

28a. Dete of Injury (Month, Day Year)

29c. Licensa number

1 ☐ Yes 2 ☐ No

28c. tnjury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner es steled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner steled. 29d. Data signed (Monthy Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

7600 Osler Drive

Suite 411

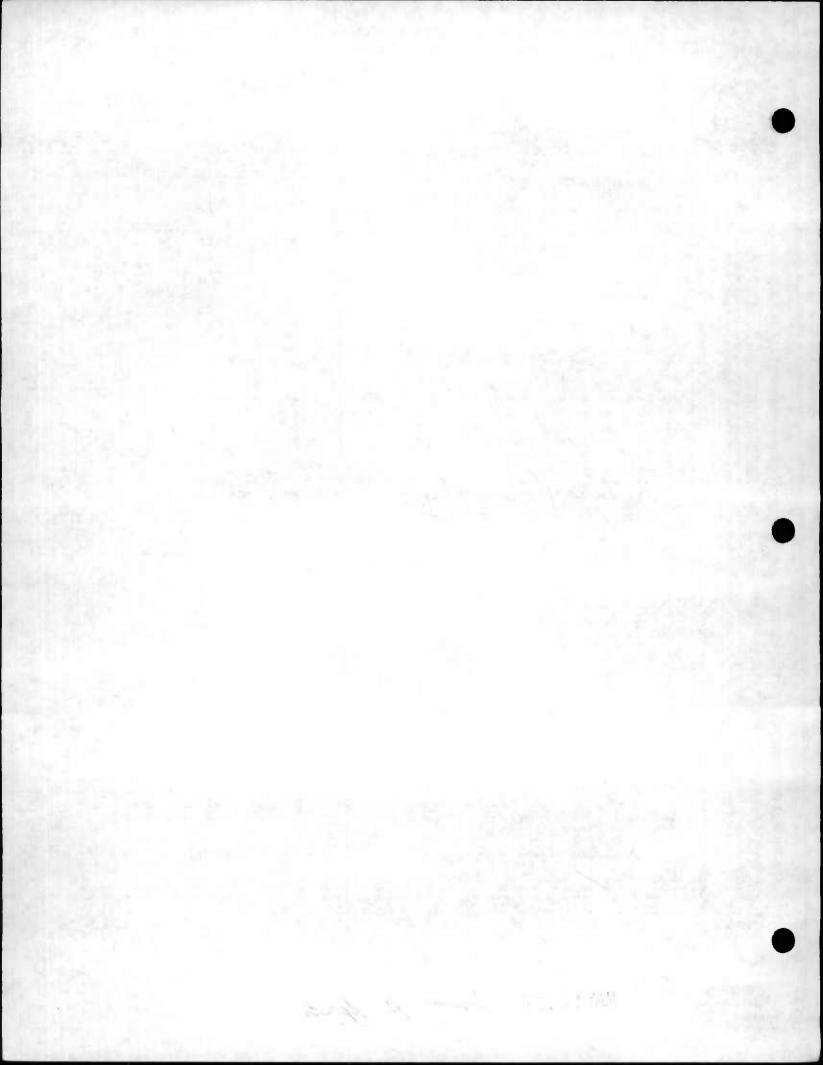
26. Piece of Deeth (Check only one)

Other: 4□ Nursing Home 5□ Aesidenca 6□ Other (Specity)

28d. Describe how injury occurred

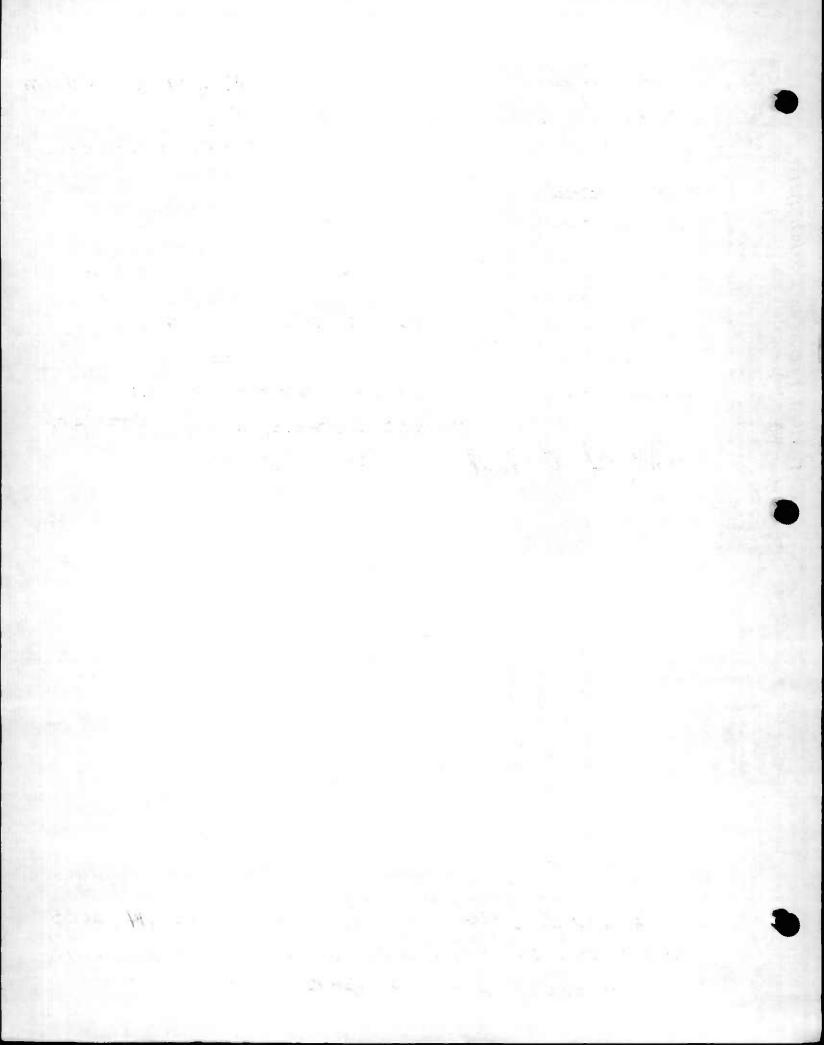
Baltimore MAryland

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 0 15965

					Cen	tificate	of C	Death		R	eg. No.			
Physic	ian	Decedent's Neme (First, Middle, La Beulah Mode Re:	*							ate of Deel		Yeer	3. Tima of Deeth	
/Med	cal	4e. Fecility Neme (If not institution, giv					Ab	o. City, Town		May		.000	5:45PM	
Exami	ner	(tal of		1/mo/	(If Under 1 Y	E	Soltim If Under 24	ore (ity		y of Deeth	(2)	
Funeral Director			□м 2√2 г 78	(111)13. 103	Yrs.		eys		Min. Jur	ete of Birth Month, Pay 1C 17	, 1921	Nort.	lece (State or Foreign try) h Carolina	
the Maryland 28a-f show notified at		10e. Stete 10b. County		10c. City,	Town or Loc	ation						1	0d. Inside City Limits	
the Marytar 28a-f show notified at	ctor	Maryland Baltim	ore		East	point							1 ☐ Yes 2 No	
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e 23s	erai								0.40 11 1		US			
within 72 hours after death with the Maryta ene. than "natural", or items 23a or 28a-f sho he Medical Examinar must be notified at	by Funeral Director	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:			Yes, specify		spenic Origin n, Mexican, P Specify:	7 (Specify uerto Ricar	res or No- n, etc.)		ce - Americ eck, White, fy: Whi	etc.	
natura dical E	bed	15. Decedent's Education 16e. Decedent's Usuel Occupation									16b. Kind of 8	Business/Inc	Justry	
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工智量	Be	17. Fether's Name (First, Middle, Last)						18. Mother's	Name (Firs	ne (First, Middle, Meiden Surneme)				
and Mental is marked o aumetic evi	2	Clarence D. Mode Martha H												
Tis man		19e. Informent's Neme/Relationship (John Boyles (Son)	Type, Print)							ural Route Number, City or Town, Stete, Zip Code)				
Health and Min tem 27 is marks other traumatic		20e. Method of Disposition		20b. Pled	e of Dispos	ition (Neme o	of		De				wn State	
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fig.		4 Donetion 5 Other (Specify) 21. Signefure & Funerel Service Licensee (1) 22. Neme end Address of Fecility									h Car	olina		
SE E		Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md.											1221	
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ysician		TIPICK, or need failura. List only										i	Intarval Between Onset and Deeth	
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£ 2	cati	2 Accident Investigation 3 Sulcide 6 Could not be						es 2 No						
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Sta	te	31. Dete filed (Month, Dey, Year)	32. Registrer	's Signetur	0				ucim	ore I	rury	und	C1 C13	
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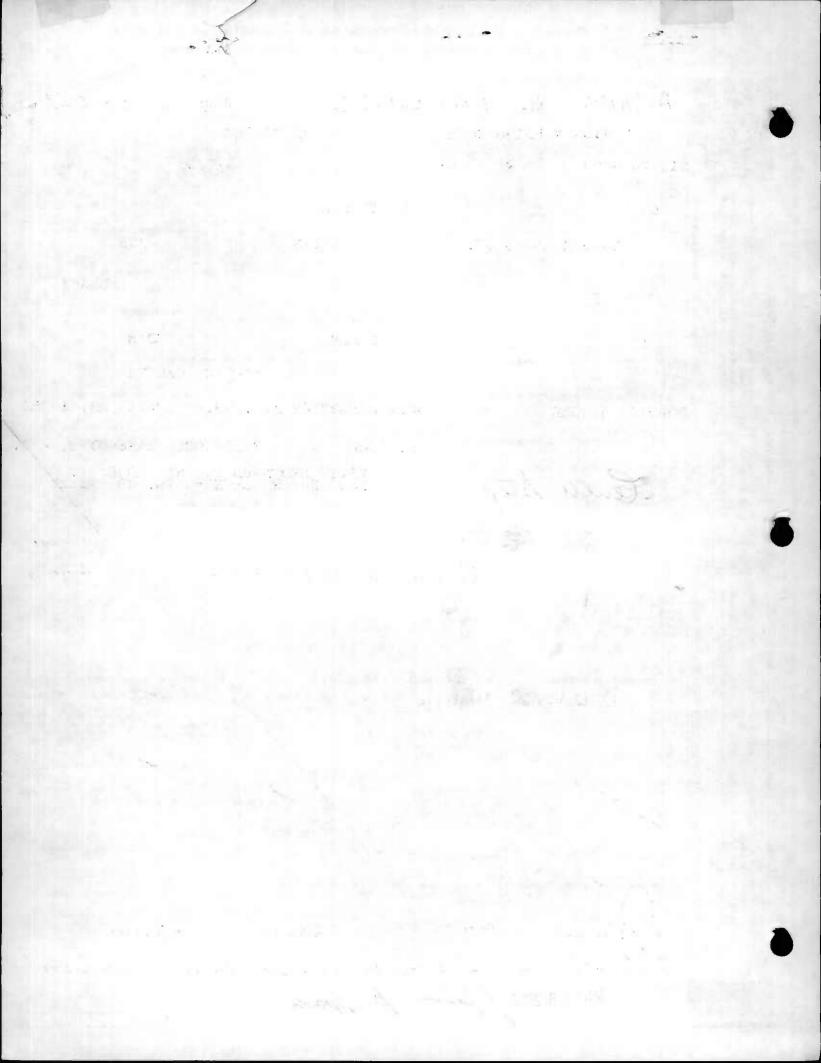


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer Month **Physician** AGNES AWLINGS 0230 MAY 00 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** DEATON NURNING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2₩ F 91 MD 219 76 8909 Yrs **Director** Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show odical Example must be notified at MD BALTIMORE 1# Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours effer death with the Department of Haalth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2, any injury or other treumatic event, the Modical Examinat Injust be no appear. 21223 USA 1800 HOLLINS ST. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes #☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 #No Specify: BLACK Baltimore, Maryland 21215-0020 Àq 3 HVidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK. Be ? WILLIE CARTER 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 8221 CHELWYNDE AVE. PHIADELPHIA PA. 19153 DOROTHY SYDNOR 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊞Burial 2 □ Cremation 3 □ Removal from State MT. 7/17/2000 LANSDOWNE, M D. ZION 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HERS FUNERAL HOME 1300 EUTAW PLACE BALTO. MD 21. Signature of Funeral Service Licensee PA. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) Stroke /Medical hour Examiner Due to (or as a consequence of): Fibrillahan Examiner attending physician end for usa es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? been signed by the s should be datached 1 Yas 2 No 3 Probably 4 Unknown Melliba p 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Was an autopsy s certificate has t director, page 2 s 1 ☐ Yes 2 ☐ No 2 400 1 TYes Hospital or Attending Physician: Be director, 25. Wes case referred to medicel 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 28c. Injury et Work? 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Dis completaly filled in 29a, Certifi 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Skg title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA D38675 5/13/00 ddress of person who completed cause of death (Item 23a) (Type, Print) 301 STPAUL PL 1 DEL MESHO LAM PALTIMORE 21202 SUITE GOS MD 31. Date filed (Month MAY 1 8 2000 32. Registrar's Signeture

Registrar

DHMH 16 Rev 6/95

State



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician EDWARD REDEMANN 2000 05 09:32A 16 /Medical 4b. City, Town, or Location of Death 4s Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** CENTER BALTIMORE BAYVIEW MEDICAL If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (in yrs. last birthdey) Birthpleca (State or Foreign Country) **Funeral** Months 1 M 2□F 214-03-4155 87 Director Feb 1,1913 MD. Usual Residence of Decedent the Merylend 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at 1 Yes 2 No Director Dundalk Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 549 Bayside Dr. USA 21222 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. rther than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tools .. Pages 1 end 2 should be filed witten of Heelth and Mentel Hygien tant: If Item 27 is marked other thy jury or other traumatic event, the Die Maker 8 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Margaret Lawson Herman Redemann 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 549 Bayside Dr. Dundalk, Md. 21222 Redemann Carol 20b. Place of Disposition (Neme of cemetery, cremetory or other place) May 20 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any Injury or Morelands Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2000 Parkville , MD. 21. Signatu ap of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk, 7110 Sollers Point Rd. Dundalk, Md 21222 23a. Part I. Enter the disease or complications that caused the death of one enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset end Desth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ASPIRATION 10 HOURS PNEUMON/A Examiner Due to (or as a consequenca of): Physician/Medical Examiner 7 YEARS CANCER ARYNGEAL the attending physicien end hed for use as the buriel-transit certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or ss s consequence of) 7 YEAR TRACHEOSTOMY Due to (or ss a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown FAILURE RENAL p 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 : certificate has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To Inpatient 2 ER/Outpatient 3 DOA After this

Box 68760 P.O. I Division of Vital Records,

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

31. Date filed (Month, Day, Year) MAY 1 8 2000

27. Manner of Death

1 Natural 2 Accident

3 Suicida

29a Certifier

4 ☐ HomicIde

29b. Signature and title of certifier

29c. License number

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of sxamination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted. 29d. Date signed (Month, Dey, Year)

LIL

5 Pending

investigation

6 Could not be determined

20300

5/16/2000

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

30. Name and siddress of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENUE BALTIMORE, MD 21224

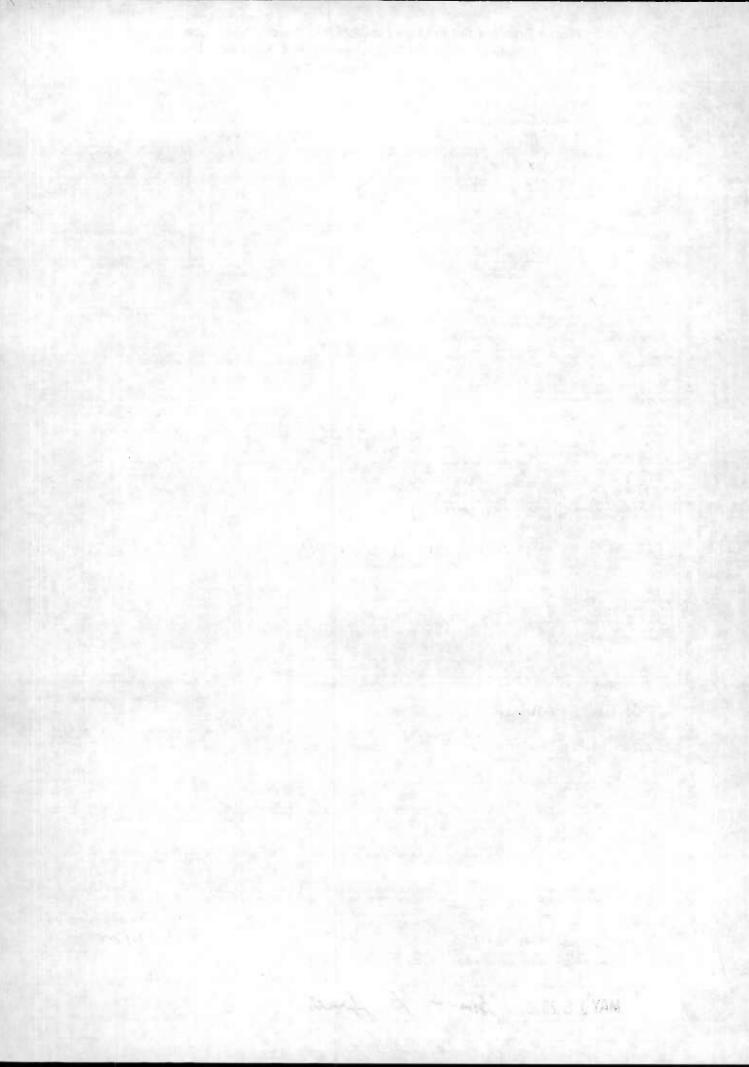
32. Registrer's Signatura

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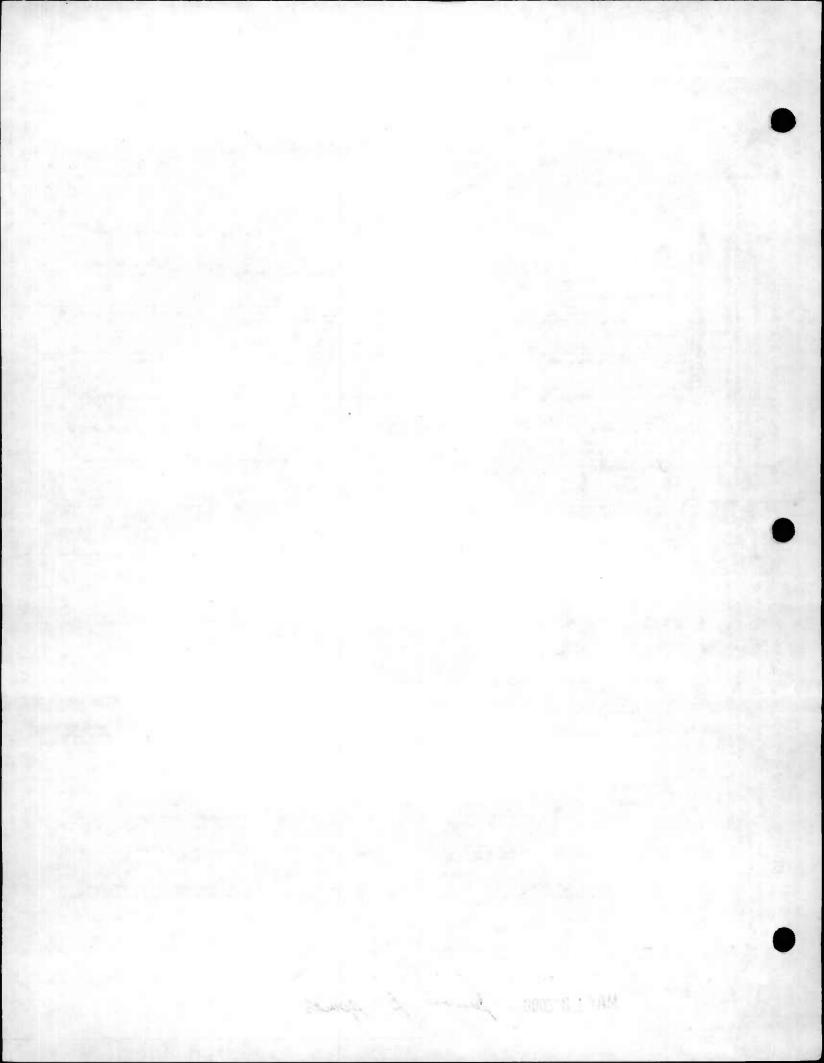
28b. Time of

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Month May **Physician** 12 2000 4:00 PM Edward C. Ruley /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins Bay View Medical Center Baltimore N/A 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Pay Year) 7 1923 Committy and Page 17 1923 Committy and Page 18 1923 Committy and Page 18 1923 Committy and Page 18 1923 Committy and Page 18 1923 Committee or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 76 Yrs. 215 12 1696 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or itema 23a or 28a-1 show any Injury or other traumatic event, the Market Eventral must be notified an other. 10b. County 10c. City, Town or Location 10d. Inside City Limits Mary land 1 ☐ Yas 2 ☑ No Baltimore Director Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 Chesaco Ave. U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Giva Year or Dates: 1944 Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 NWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Seaman Merchant Marine 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Ruley Agnes Miller 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Dawn M. Nee, Esq/Attorney One East Franklin St., Baltimore, MD 21202 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete May 17 2000 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Baltimore 4 ☐ Donation 5 ☐ Othar (Specify) Green Mount Cemetery 22. Name and Address of Facility Lilly & Zeiler, Inc. Funeral Home 21. Signature of Funeral Service Licensee atherene M. 1901 Eastern Ave., Baltimore, MD 21231 perler 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intervat Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner LOWER e Hospital or Attending Physician: The law requires that the death certificate be executed be bounded about after death.

Funeral Director: After this certificate has been signed by the attending physician and letely filed in by the funeral director, page 2 should be detached for use as the busin-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): EHYDRA710M Box 68760 Due to (or as a consequence of): EMENTIA P.O. F Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? DEPRESSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24b. Were eutopsy tindings eveilable prior to completion of cause ot death? 24a. Wes an autopsy performed? 1 Yes 1 Yes 2 No 25. Wes case raferred to medical axaminer? 8 26. Placa of Death (Check only one) Medical Certification: To 1□ Yes 2□ No Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Neturet 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be detarmined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the ceusa(s) and menner steted. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) ınder elle 30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print) Baltinere 31. Dete filed (Month, Day, Year)
MAY 1 8 2000 21 32. Registrer's Signature State Registrar



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day **Physician** 3:25pm Daniel J. See may 15,2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner osedale
If Under 24 Hrs. 8. Dat Baltimore Franklin Square Hospital Center 8. Date of Birth (Month, Day, Year) Tine 1,1932 If Under 1 Year Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1X M 2□ F 67 Director 219-28-6857 Md. Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Essex 1 ☐ Yes 2√ No Director 288-7 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? 23a or 1606 Rickenbacker Rd. 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

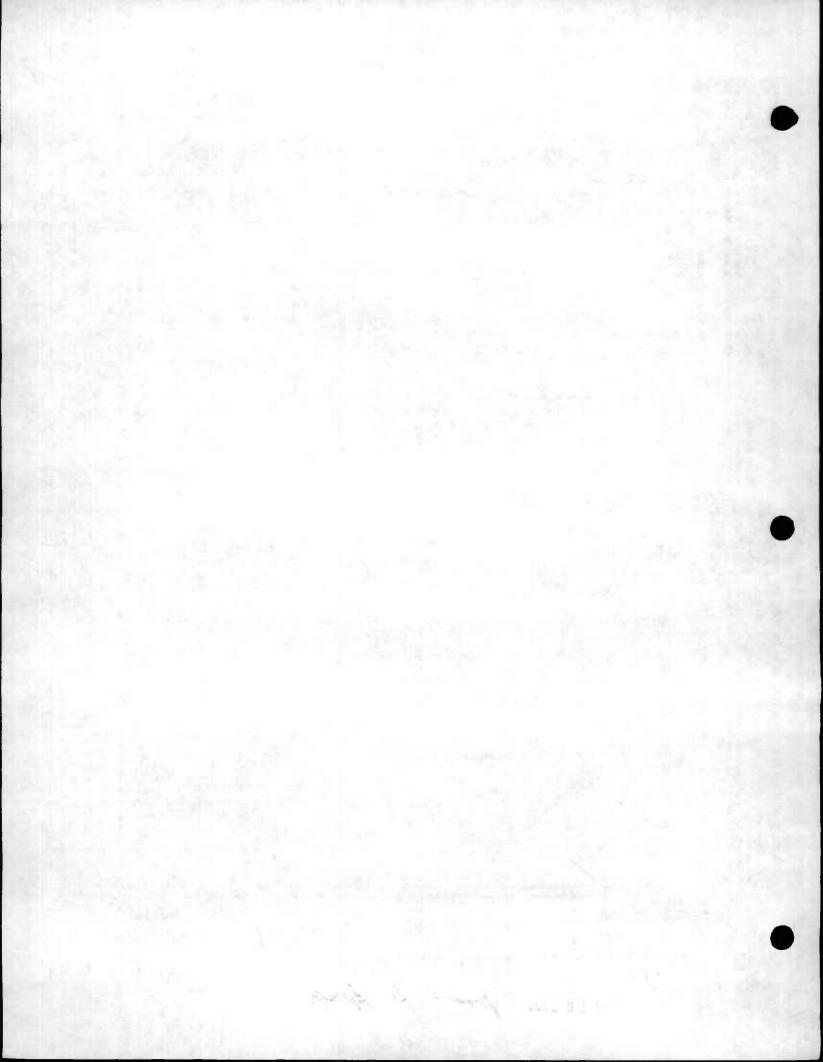
1 Yes DNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc Pages 1 and 2 should be filed within 72 hours after Never Merried 2 Married Maryland 21215-0020 8 1 Yes ₽ No Specify: SpecifyWhite PV 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Disposal Plant 8 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ä See Daniel See Gladys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a: If Item 27 is Wanda Drumheller friend 67 Seversky Ct. Essex Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) May18 Metro Crematory Baltimore 2000 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Parti! Enter the disease, or complications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailute. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical lyocardial Infarction 36hours Examiner Physician/Medical Examiner Arter The law requires that the death certificate be executed use es the bunal-transit Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Due to (or as e consequence of) P.O. Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, p Be Completed 24b. Were autopsy tindings page 2 should 24a. Was an autopsy eveilable prior to completion of cause of death? performed' certificate hes 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division Injury 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homlcide within 24 hours a To the Funeral C Hospital Sertifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examines: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) edicai 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 80196618 MO 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) or Allen For sythe 9000 Franklin Square Drive Baltimore, Mary land 21237 32. Registrar's Signature 8 Registrar

ORIGINAL

1 2 mod 8005 8 I YAM

Physician	1. Decedent's Nama (First, Middla, Las	st)	Train Print			2. Data of Daar Month	eg. No. h Day Yaar	3. Tima of Death	
ledical	SHIRLEY		W 1191	SACHS		MAY 16,	2000	4:50PM	
aminer	4e Facility Nama (If not institution, give	a street and number)			4b. City, Town, or Le	ocation of Deeth	4c. County of Dea	th	
	ROLAND PARK PLAC			If Undar 1 Year	BALTIMOR If Undar 24 Hrs.			N/A	
eral ctor	5. Sociel Security Number 6. S 219–32–1107 1 Usual Rasidance of Decedant	M 2□XF	yrs. last birthday) 91 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey NOV - 28	, Year) 9. Bir , 1908	thplace (State or Foraign ountry) MD	
N N	10a. Stata 10b. County MD N/A		City, Town or Lo					10d. Insida City Limits 1 ☑ Yes 2 ☐ No	
Director	10e. Street and Number		DALITIONE	10f. Zip Code		1	0g. Citizen of Whet C	•	
	830 W. 40TH STRI	eet ee		101. Zip Code	21211		U.S.A.	ountry ?	
by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 🔯 Widowed 4 Divorced	12. Was Decedant Evar Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates:		Was Decedant of H If Yas, specity Cub 1 ☐ Yas 2 ☑ No	dispanic Origin? (Sp an, Maxican, Puarto Specify:	ecify Yas or No- Rican, etc.)	14. Race - Am Bleck, Whi		
Completed	15. Decedent's Ed (Specify only highast gra	ducation da completad)	16a. Deced	dent's Usual Occup	pation during most of work	ing	16b. Kind of Bustness	/Industry	
du	Elemantary/Secondary (0-12)	College (1-4or 5+)	lifa. I	DO NOT usa retire	d)				
	17. Fathar's Nama (First, Middla, Last)		HOMEN	IAKER	18. Mothar's Nam	a (First, Middla, I	OWN HOME Meidan Sumama)		
To Be	MICHAEL		BLUM		MINNIE		BLA	USTEIN	
-	19a. Informant's Name/Ralationship (7	Type, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Routa Numbai	, City or Town, Stata,		
	STEPHEN H. SACHS	S / SON	5 ROL	AND MEWS	, VLG OF	CROSS KE	EYS, BALTI	MORE, MD 2121	
20	20a. Method of Disposition		Ob. Ptace of Dispo	sition (Nama of matory or other pla	ca)	Date	20c. Location - City or	Town, Stata	
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ans	21. Signature of Funeral Service Licenta	Lullen	. 8	2. Nema end Addre	TERSTOWN	ROAD - F	INSON & BROPIKESVILLE	, MD 21208	
ian cal	Immediate Cause (Final disease or condition	one causa on aach lina.	Res p	rotory	Gile	ne		Approximete totarval Batween Onsat and Death	
ē E	resulting in death)	Due	to or as a colono	tuence at				71000	
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	Sequentiatly list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events								
Medical Examir	that initiated evants rasulting in deeth) Last	Dua	to (or as a conseq	uanca of):			11 (5)		
/ Physician/	Pert II. Other significant conditions or	and about a great but as	t requising in the	adarbijas anusa si	us is Bod I	22h Did to	phaga a contribut	to the cause of deeth?	
by Physician/M	Port II. Other significant conditions of	OHP	trasulting in that o	ndanying causa gi	vali in Fait I.	1	23b. Did tobacco de contribute to the cause		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death May 12, 2000 John W. Smallwood 3:30 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Daeth Westminster 1013 Sharon Lane Carroll 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days X M 20 F 58 217-38-1044 Nov 6, 1941 Maryland Usual Rasidenca of Decedan 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas X2 No Maryland Carroll Westminster 10e Street and Number 10f. Zin Code 10g. Citizan of What Country? 21157 1013 Sharon Lane USA 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 12. Was Decedant Evar in U,S Armed Forcas? 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas ¥☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Baltimore Air Coil Welder 8 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Louis Osbin Smallwood Frances Margaret (Unknown) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zlp Coda)

1013 Sharon Lane Westminster, Maryland 21157

05/16/00

20c. Location - City or Town, Stata

Elkridge, Maryland

Physician /Medical Examiner

Hygiene.

Department of Health important: If Itam 27 is

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Physician

/Medical

Examiner

Direct

Funeral

Be

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20a, Mathod of Disposition

Mrs. Sandra Smallwood

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4 ☑ Donation 5 ☐ Othar (Specify)

30. Nama end addrass of person who complated

31. Data filed (Month, Day, Year) MAY 1 8 2000

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32. Registrar's Sig

re of Furbral Se

Funeral

Director

Iohn Smallwood

physician and s the buriel-tran

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certificate

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after death.

Director: After

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Division of Vital

requires that the death cartificete be executed

Examiner Physician/Medical Completed Be 2

latter Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 1400535 23a Fart1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Interval Batwaan Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Acute Mucicavalved

Dua to (or as Consaguanca of): Boten Covonas Myseus Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence pf): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1) Yee 2 No 3 Probably 4 Unknown Chronic Obstractive Palmonau Dicease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Placa of Death (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascriba how Injury occurred Certification: 1 Natural 5 Panding 1 Yas 2 No invastigation 2 ☐ Accidant 6 Could not be datarminad 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) Placa of Injury - At homa, farm, straat, factory, uffice building, atc. (S) 4 Homicida 1 Certifying Plu 2 Medical Experi 29a. Cartifian cian: To the est of my knowl ed at the time, date and place, and due to the cause(s) and manner as stated. Medical iner: On the posis of examinati and magner stated. (Check only one) ation, in my opinion, death occurred at the time, data and place, and due to the causa(s) 29b. Signatura and titla of certifi 29c. Licansa number 29d. Data signed (Month, Day, Year)

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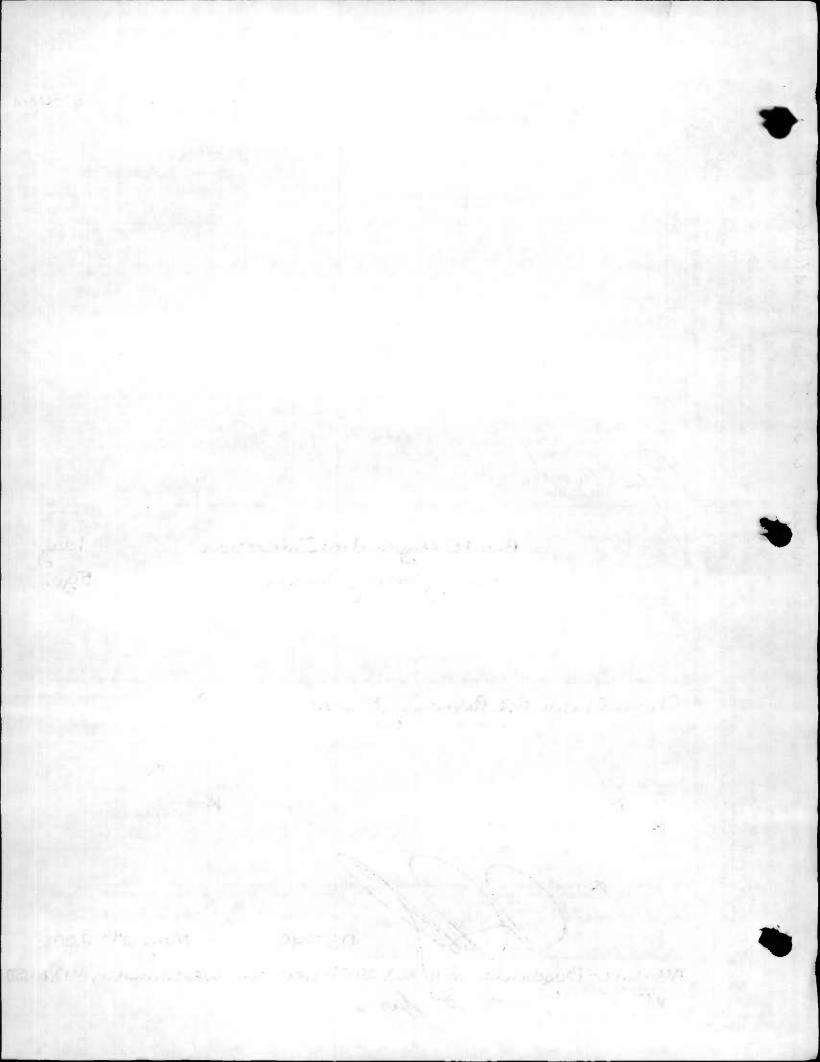
2005 Sevier Bue. Westminister, MM, 21157

20b. Placa of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park, Inc.

22. Name end Address of Facility

Registrar



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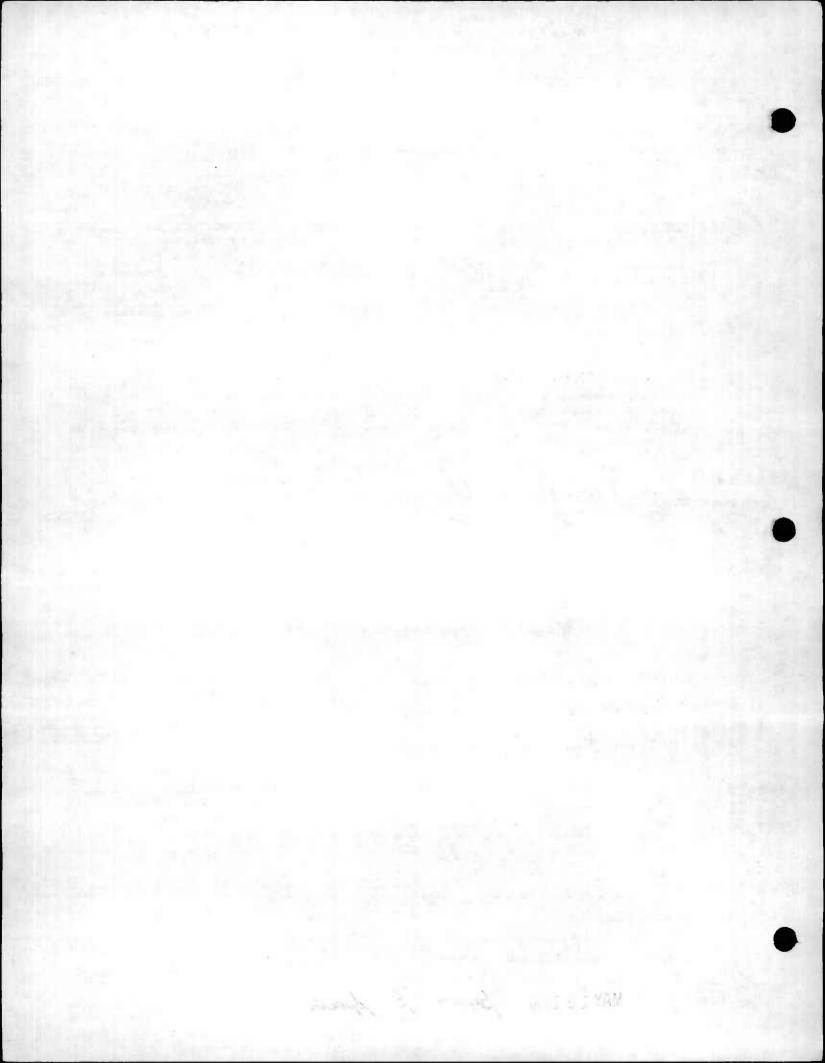
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Exami	ner	4e Facility Neme (If not institution, give 1925 EAST CHASE				4b. City, Town, or BALTIMOR		4c. County		
5		5. Social Security Number 6. Se		st birthday)	If Under 1 Year				/ A	lace (State or Foreign
Funeral Director			2 ^{M 2□F} 27	Yrs.	Months Days	Hours Min.		, Year)		lace (Stete or Foreign try)
7		Usuel Residence of Decedant					4/8/73		T-	SATWD
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with with	ō	10e. Street and Number	TONILLE		10f. Zip Code	239		Og. Citizen of V	vnat Coun	itry?
heath me 23	Funeral Director	1147 ELBANK AV	12. Wes Decedent Ever in U,S	S. 13. V			Specify Yes or No-	USA 14. Rece	- Americ	en Indien,
A 1 A 13-UUAU d within 72 hours after death with the Maryland glane. It than "natural", or flama 23a or 28a-f show the Madical Exercities must be notified at	by	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give X Yeer or Detes:		Yes, specify Cub	an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Specify.	k, White,	etc. ACK
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Mary laind Id 2 should be file the end Mentel Hy The marked othe traumatic event,	o Be	ALFRED PETERSO	N				IANIE PE		23	
should Me	Ĕ	19a. Informent's Neme/Reletionship (T		19b. Meilin	a Address (Street		ural Route Number			Code)
in the stand of the stand of other traum		STEPHANIE PETE								21239
permit. Pages 1 and Depertment of Health Important: If New 27 any Injury or other to page.		20e. Method of Disposition	20b. Ple	ace of Dispos	sition (Nama of natory or other ple			20c. Location -		
mit. Pages 1 ar pertment of Hea portant: If Nem. 3 y Injury or other		1 Buriel 2 Cremetion 3 F 4 Donetion 5 Other (Specify)	temovel from State		MORIAL		/22/200	00 BZ	т.т	COUNTY M
permit. Pa Depertment Important: Inny Injury		21. Signature of Funeral Service Licens	1111		Name end Addre	ess of Fecility				
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ifficate be executed g physician and as the bunal-transit	Examiner	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as e conseq	uence of):				t	
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death of for	sicia	Part II. Other significant conditions co	ntributing to death but not rasul	ting in the ur	derlying causa giv	ven in Part I.	23b. Dld to	obacco use con	tribute to	the cause of death?
requires that the death centered is signed by the attendination hould be deteched for use	by Physician/M						1 🗆 Y	es 2 No	3 Prot	bably 4 Unknow
	Completed by	7				7	24a. Wes e perfor	n autopsy med?	COL	ara autopsy findings eilable prior to mpletion of cause death?
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sician: The law certificate has b	Be	25. Wes cese rafarred to medical exeminar?					ath (Check only or	na)		
Physician: rthis certific ral director,	2	1XXYes 2□ No		R/Outpatien		4 U Nursing F	Home 5 Reside			AT SCENE
frer the uners	on:	27. Manner of Death 1 ☑ Neturel 5 ☐ Pending	28a. Date of tnjury (Month, Dey Year)	28b. Tima of tnjury	28c. tnju		28d. Describe h	ow injury occurr	ed	
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Livision of vital the law rai for Attending Physician: The law rs after deeth. al Director: After this certificate has led in by the funeral director, page 2:	Certification:	4 Homicide detarmined	28e. Plece of Injury - At hor building, etc. (Specify)		et, lactory, office		City or Town	n, State)	or or mura	l Route Number,
Hospi 14 hou Funer tely fill	Medicai C		stctan: To the best of my know ner: On the basis of axaminatic and menner stated.							
To the within 2 To the comple	M	29b. Signature and title of certifier /	and married didied.		29c. Licens		2	9d. Dete signed	(Month,	Dey, Year)
F 3 F 0		Man la	of mes		0.0	C.M.E		MAY	16,	2000
		30. Name and address of person who co	ompleted ceusa of death (Item	23a) (Type, I	Print)					
1		TIAPMILL				. Baltimo	ore, Mary	land 21	201	

DHMH 16 Rev 6/95

Registrar



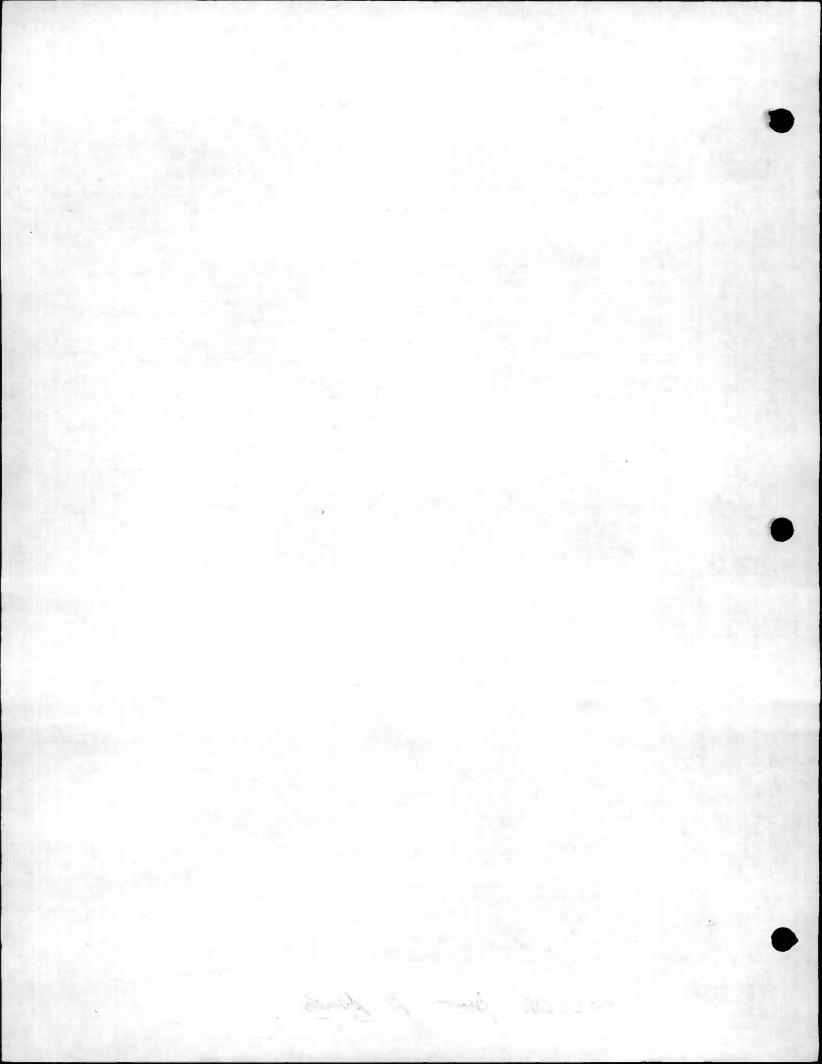
				Certificate o	f Death	Re	g. No.		9/4
Physician	1. Decedent's Name (First, Middle, I					2. Dete of Death Month	Dey	Year	. Time of Death
/Medical	4a Facility Name (If not institution, g	WILL:		RMAN WALDEN	4b. City, Town, or Lo	May Death	7		2150
Examiner	FALLSTON GENE	RAL HOSPITA	AL		FALLSTO	N	4c. County	ARFORD	
Funeral Director	491-32-4364	Sex 7. Ag	e (In yrs. last bi	rthday) If Under 1 Yes Months Day	ar If Under 24 Hrs. S Hours Min.	8. Dete of Birth (Month, Day Aug • 13	1928	9. Birthplaca Country) Misson	uri
pos Bu	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	n or Location				10d.	Inside City Limit
with the Maryland a or 28a-f show the notified at Director	Md. Harfo	rd		Fa	llston				1 ☐ Yas 200 N
result with the M ems 23s or 28s-f r. must be notifie meral Directo	10e. Street and Number 3427 Widows C	are Road		10f. Zip Code	21046	10	g. Citizen of W	What Country? USA	'
O20 urs after alf. or h Examina by Fu	11. Marital Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? XIX Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)		a - American I k, White, etc. Whi	
1 21215-0 ed within 72 ho sygiene. er their "netur e, the Medical. Completed	15. Decedent's (Specify only highest of		16a	Decedent's Usual Occ (Give kind of work dor	supation ne during most of work red)	ing	6b. Kind of Bu	siness/Indust	ry
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Be C	17. Father's Name (First, Middle, La.				18. Mother's Nemo			Θ)	
should by and Mental merked immitte ev.	Thomas Edwar	d Walden			-	.e K McCl			
re, Mar 1 and 2 sh Health and wm 27 is m other traum	19a. Informant's Neme/Reletionship Charles Walden		3	o. Mailing Address (Stre 427 Widows	et and Number or Run Care Road	Fallsto	City or Town, on Md.	Stete, Zip Co. 21047	de)
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Ball Depart Import any in	21, Signature of Funerel Service Lic	10	00.	22. Name and Add	11v Funera	al Home o	of Esse	x	
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Physician / /Medical	Immediate Cause (Finel	Access to the second	-	1	Y-0 1	++	-1.	On	ervat Between nset and Death
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J, executed an and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate		Due to (or as a	consequence of):					
flicate be ex physician as the bunal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	c	Due to for se a	consequence of):					
OX 68760, certificate be executed nding physician and use as the bunal-fransit n/Medical Examin	resulting in death) Last	d	Due to (or as a	consequence or,					
Geath ce attend d for us.	Pert II. Other significant conditions	contribution to death by	ut not reculting i	the underbine source	nison in Roya I	22h Did tol	2000 1100 000	tribute to the	a source of dead
S, P.O. BO) as that the death ce gned by the attend: be detached for use by Physician/	Previous	Cerebr	1 Vasc	war A	cordent	1 T Ye			e cause of deati
of Vital Records, P.O. Box 68760, Physician: The law requires that the death cartificate be executed this cartificate has been signed by the attending physician and rial director, page 2 should be detached for use as the burial-transit of the Completed by Physician/Medical Exaministic Programment of the Completed of the Completed of the Completed of the Complete o	Essentia	Hype	v tens	5102		24a. Wes en		availat	autopsy findings ble prior to letion of cause th?
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f Vital I yalcian: The s certificate director, pag	25. Wes case referred to medical examiner?	Manakati	/	_	26. Place of Deet	h (Check only one	9)		
Physic of this of ral direction of T.	1 ☐ Yes 2 ☐ No 27. Manngref Death	Hospitel: 1 Inpatie		Applicant 3D DOV		me 5 Reside			
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Division of the or attending P is after death. In Director: After the din by the funers Certification:	3 Suicide 6 Could not determine	he -	ury - At home, fe c. (Specify)	arm, street, factory, offic		28f. Location (Str. City or Town,	eet end Numbe Stete)	er or Rurel Ro	oute Number,
Hospit 14 hour Funer tely fill	29a. Certifier 1 Certifying F (Check only one)	hysician: To the best of miner: On the basis of and manner sta	examination an	o, death occurred et the d/or investigation, in my	time, date and place, opinion, deeth occurr	end due to the ca red et the time, da	use(s) end ma te end plece, e	nner as stated and due to the	d. cause(s)
To the vithin 2 To the comple	29b. Signature and title of certified			29c. Lice	nse number	29	d. Date signed	i (Month, Day	, Year)
	TA	1	-	DI	9582	1	Yav	16 2	nnn
0	30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)	I au / ct	veet,	NI	100	14
	MANNEL M.	LXZAT	INI	10 8	Lean 311	reel /	Toera	er	varyla
State	31. Date filed (Month, Day, Year)	32, Registra	ar's Signature	4 /	1		-10		/



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Leslie Diane Wolf					olale (JI Waryi	and /	Department of Health and Certificate of Death	R.	1597
AMEND ITEMS:	#23	PART	Ι,	II,	27,	28A-F	PER	Certificate of Death	Reg. No.	1021

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hysician	_	LESLIE		DIAN	E		WOLE	י	Month	Day 1.5 . 2000	Year	1440	
/Medical Examiner		Facility Name (If not institution, gir	ve street end number,						or Location of Dea		ty of Deeth	1440	
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neral	5.	Social Security Number 6. 5		ge (In yrs. las	st birthday)	If Under		If Under 24 F	rs. 8. Date of B	irth		place (Steta or Foreigntry)	
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cto		MD N/A		BALT	'IMORE	Ξ						1 X Yes 2 □ N	
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ROSE WOI 20e. Method of Dispo 1 Deniel 2 4 Donetion 5 21 Signature of Fine	4 Donetion 5 □Other (Speci	BETH	EL MEMORIAL PARK 5/16/00 R					RANDAI	LSTO	VN, MD			
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	30). Neme and address of person who	completed cause of	death (Item 2	3a) (Type,		ميلمك	Pla Fra		May 1	0, 20	00	
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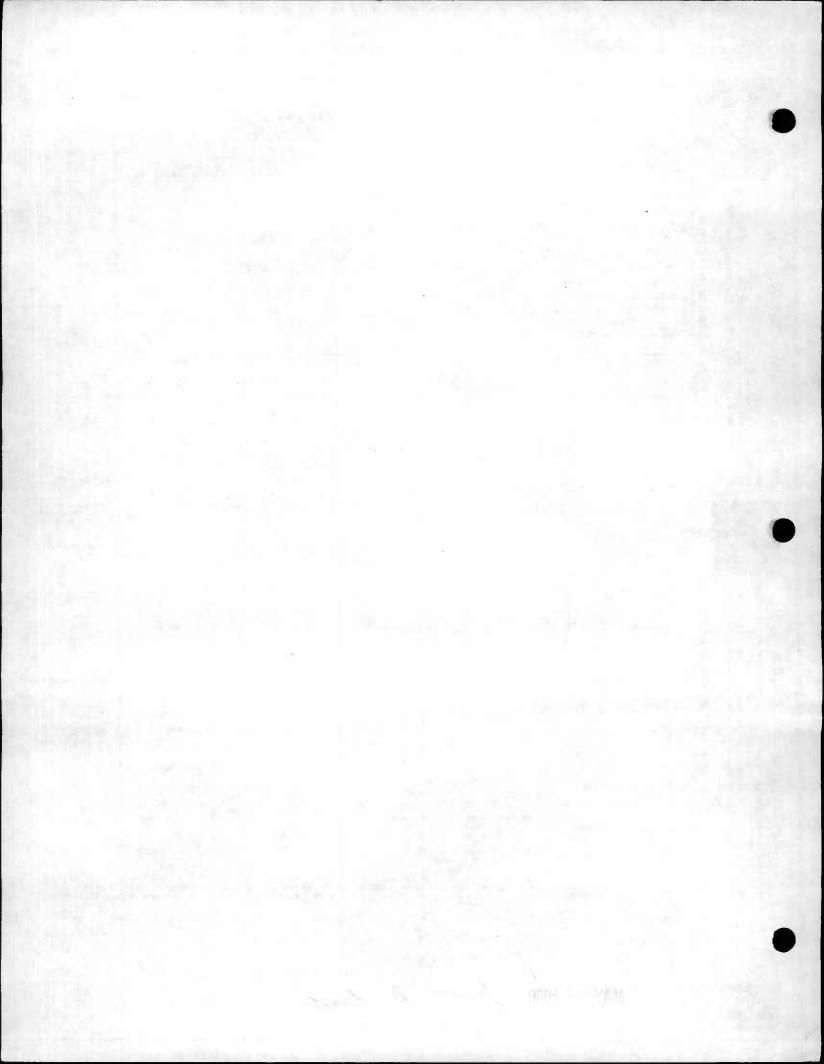
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MARCUS WEITZ MAY 15, 2000 8:30 PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner 2500 W. BELVEDERE AVENUE #516 BALTIMORE N/A If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 29, 1912 Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1XM 2□F Months Hours 578-03-0911 87 HUNGARY Director Usuel Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location Hygiene. pther than "natural", or itema 23a or 28a-f show ent, the Medical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 No Director MD N/A BALTIMORE 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 W. BELVEDERE AVENUE #516 21215 U.S.A. death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DESIGN DRAFTSMAN WESTINGHOUSE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Department of Health and Mental Importants if them 27 is marked or any injury or other traumatic eve Pages 1 and 2 should be HARRY WEITZ FANNIE SIGEL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) HENRY WEITZ / SON 5 WOODSMEN COURT - REISTERSTOWN, MD 21136 20b. Placa of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 XBurial 2 Dg 3 DRemoval from State BETH TFILOH CEMETERY 5/17/00 WOODLAWN, MD 4 Donation 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. MD 21208 8900 REISTERSTOWN ROAD - PIKESVILLE, lications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or as e consequence of) Physician/Medical Examine 1905the Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) physician: the burial Box 68760. Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? È 1 Yes 2 No 3 Probably 4 Unknown Chronic renal Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy Prostate concer performed? The law Demento 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 80 26. Plece of Deeth (Check only one) Ho spitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No edical Certification: To 뷜 28a. Dete of Injury (Month, Dey Year) 27. Manger of Death 28c. Injury at Work? 28d. Describe how Injury occurred Athor or Attending 1 Neturel 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - Al home, ferm, street, factory, offica building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.

2 ■ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number title of certifier 04037 5/16/2000 MO 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 90 Paintais Mill Ref awings Mills, MD 21117 Dr. Harry Kaplan, Mb 31. Dete filed (Month 1 8 2000 32. Registrer's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Physician **EDMUND ASKLAND** SR April 29, 2000 11:10 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6993 Amber Fields Court Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) November 30, 1922 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 121M 2□ F Yrs. 100-12-1212 Director New York **Usual Residence of Decedent** permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Deservations of Health and Mental Hyglane. Important: If them 72 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Medical Exemities must be notified at 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Wicomico Salisbury 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6993 Amber Fields Court by Funeral 21804 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 ⊠Yes 2 □ No Merchant If Yes, Give Year or Dates: Marines 1 □ Never Married 2 N Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 New York Fire Dept. Fireman 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Be Omond Askland Madeline Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Irene J. Askland/Wife 6993 Amber Fields Court, Salisbury, MD 21804 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal Irom Stata 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 5/3/00 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 **Physician** Immediate Cause (Finel diseasa or condition resulting in death) /Medical Examiner Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burie Dua to (or as a consequence of): been signed by the s should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 8 26. Placa of Death (Chack only ona) Other: 4□ Nursing Homa Seasidanca 6 □Othar (Specify) Medical Certification: To 1□ Yes NO No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 Yas 2 No 2 Accident investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the fi 3 ☐ Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only nd/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) 29b-Signature and title of certifier M and address of person who completed cause of death (Item 23a) (Type, Print) IVA 5 State Registrar



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month BODDY **Physician** ALONDRA TAREISHA 7.30 AM MAY 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENNER KRIEGER INSTITUTE 707 N. 3 ROADWIBALTIMORE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M XXF Yrs Director 217-51-9229 Feb. 13,1998 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2(No Director Maryland Ceci1 Perryville 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 10 Brookside Drive 21903 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Never Married 2 Married 8 1 Yes 2 No Specify Specify: **Black** þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) None Never Employed None Never Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H Nem 27 is marked off r other traumatic ever Unknown Gwendolyn M. Boddy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 10 Brookside Drive, Perryville, Maryland Gwendolyn M. Boddy (mother) 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c Location - City or Town, State Department of P Important: If Ite any Injury or off 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from State Zoar A.M.E. Church Cemetery 5/6/00 Conowingo, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 loniasin. atternor, or 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical fmmediate Causa (Final CEREBRAL WHILL COMPLICATIONS 30-60 MINS disease or condition resulting In death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the bunial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Causa (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Due to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Y88 7 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parlormed? Completed this certificate has 20 No 1 Yes 1 ☐ Yes No or Attending Physician: Be 25. Was casa referred to medical 26. Place of Daath (Check only one) Yes 2□ No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after death. 1 Yes 2 No 2 ☐ Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicida Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and tale of partition 29c. License number D0052879 MAY 2, 2000 30. Name and address of person who complated cause of death (Item 23a) (Typa, Print) KENNEDY KRHEGER INSTITUTE, BALT MARC

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

Maryland 21215-0020

Baltimore,

Box 68760,

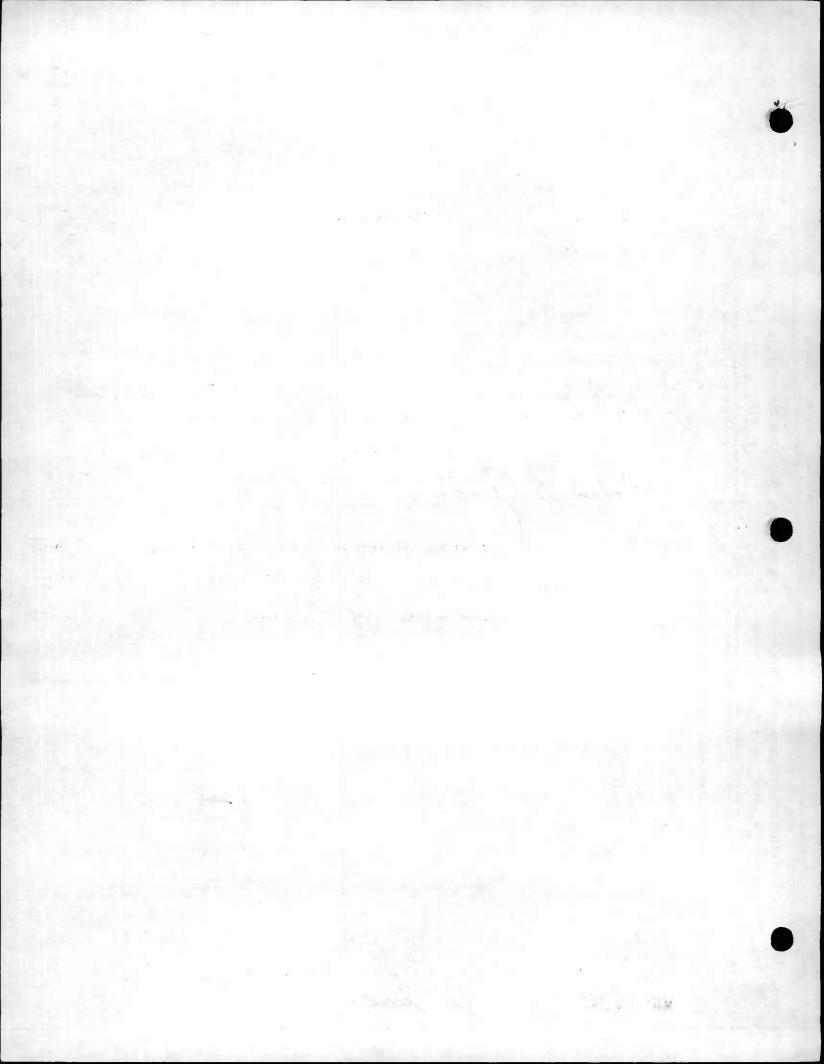
P.O.

of Vital Records,

Division

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Amend item #26-#5 05/10/2000 cchd rjw Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Physician Month Year Ruth M. Benson Mau 4 2000 10:10 pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 56 Susquahannoch Blvd. North East Cecil If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
May 10, 1914 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 212-01-7519 85 Vre Pennsylvania Director Usual Rasidence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yas 2 No Directo Maruland Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23s or adical Examiner must be r 355 Biddle Street 21915 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No If Yas, Giva Year or Datas: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) then College (1-4or 5+) 12 Clerical Worker DuPont/Chemical 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other traumetic event Be John W. Davis May E. McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward S. Benson/Son Rt 1 Box 67 CC Poca, WV 25159 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Dete 1 XBurial 2 Cremation 3 Removal from Steta 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 15-8-00 Chesapeake City. MD 21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Fecility R. T. Foard Funeral Home, P. A. 318 George Street Chesapeake City, MD 21915 oogie ichaid 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwean Onset and Death Physician /Medical Immediete Ceuse (Final disaasa or condition rasulting in death) (multiple). Liver Cacinia. Examiner Due to (or as a consequence of): Crecinen attending physicien end for use as the burial-transit Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of) P.O. Box 68760, 89 Corcenonia certificate be Physician/Medical Dua to (or as a consequence Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yes 2DN 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 32 hesidence 6 Cousin's residence 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menger of Death 28b Time of 28c. Injury at Work? 5 Pending investigation To Netural after death. 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 24 hours after d Funeral Direct letely filled in by 4 ☐ Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30. Nama and address of person eath (Item 23a) (Type, Print) West main st 31. Data filed (Month, Dey, Year) State MAY 0 9 2000 Registrar



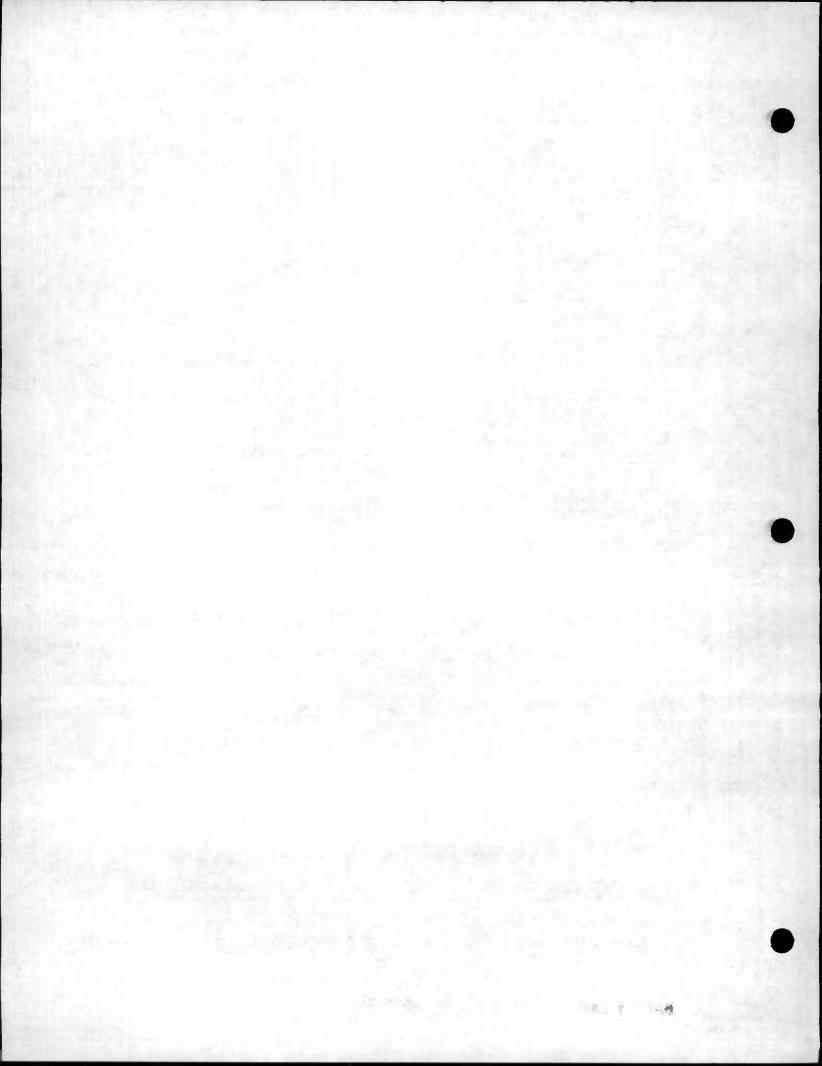
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Irene Ella Carter May 1,2000 8:10 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Union Hospital E1kton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min August 24, 191 3 EIKton, Md. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TF 86 Yrs. Director 217-16-1022 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County worke ! 10c. City, Town or Location 10d. Inside City Limits d other than "naturel", or fams 23a or 28a-f ahor event, the Medical Examiner must be notified at X□ Yes 2□ No Director De. New Castle Newark 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 308 Ashley Road 19711 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married White Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other traumatic event, the Ma Elementary/Secondary (0-12) Triumph College (1-4or 5+) Inspector 8 **Explosives** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alonzo Wood 2 Elsie Roberts 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Nancy Arrants, Daughter 140 Arrants Rd., North East, Md. 21901 Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurlel 2 Cremation 3 Removal from State Gilpin Manor Mem. Pk.5/4/00 Elkton, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 259 E. Main Street Gee Funeral Home Elkton, Md. 23a. Part 1. Enter the disease, or combications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** tmmediate Ceuse (Final disease or condition resulting in deeth) /Medical a. KULL UNGOCHNDID - IN FARCTION

Due to (or es a consequence of): Examiner CONOWARY ANTERY DISEASE

Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last burial-tran and Due to (or es e consequence of): Box 68760 Physician/Medical the 10 YEA128 RIEMOSCHEROSIS P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Medical Certification: To Be Completed After this certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Ø No rs after dean.
ral Director: After this cer.
In by the funeral director, pe Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) les 0007K63 - 80 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) 6 Rolando A. Najera, MD 111 W. High Street Elkton, Md. 21921 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 3 2000

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** Corbin John April 25th 2000 6:55 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico Nursina Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug. 15, 1929 Social Security Number 6. Sex 1 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Min 70 Yrs. 220-28-4942 Director Maryland Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Directo 28a-f Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1521 Duke Drive 21801 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No if Yes, Give Yaar or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married natural, or 1 Yes 2X No Baltimore, Maryland 21215-0020 Specify 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 11th Poultry Plant laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and 2 should be and Mental marked Corbin Nettie 2 Ernest Taylor 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 shi Department of Health and Important: If Iber 27 is m any injury or other traum 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeralene Deal/sister 1521 Duke Drive - Salisbury, Maryland 21801 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James AME Ch. Ceme. 5/02/00 Snow Hill, Maryland 21. Signature of Funeral Service License 22. Nama and Address of Facility 1213 Jersey Road - Salisbury, MD Jolley Memorial Chapel 21801 Approximate Intarval Batween Onset and Death 23a. Part1. Entar tha disaase, or complicat shock, or haart failura. List only one of s that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see on each line. **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown bengis be det þ 24b. Wera autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 1 No 1 ☐ Yes 2 No or Attending Physician; 25. Was case elerred to medical director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

[2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29c. License number 29d. Date signed (Month, Day, Year) 26 2000

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Box 68760.

P.O. 1

Records,

Division of Vital

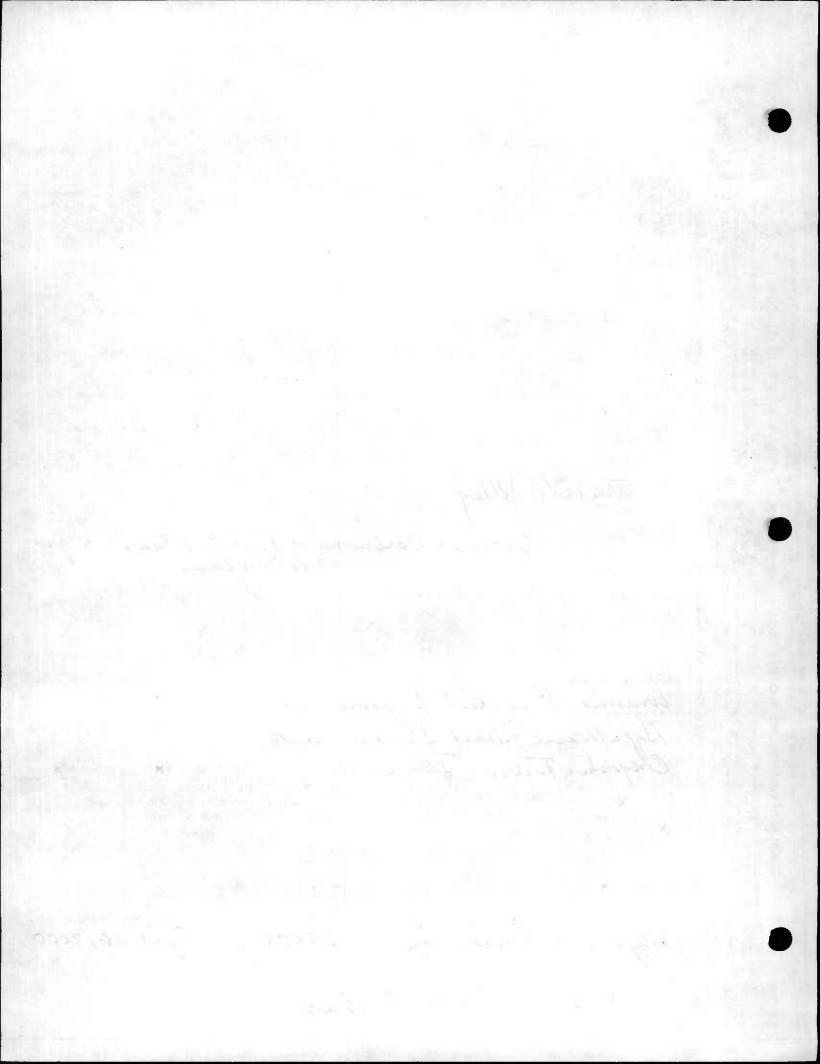
5302 Chinaberry Drive Gregorio Belloso APR 2 8 2000

32. Registrar's Signature

50. Neme and address of person who complated cause of death (Item 23a) (Type, Print)

Salisbury MD 21801

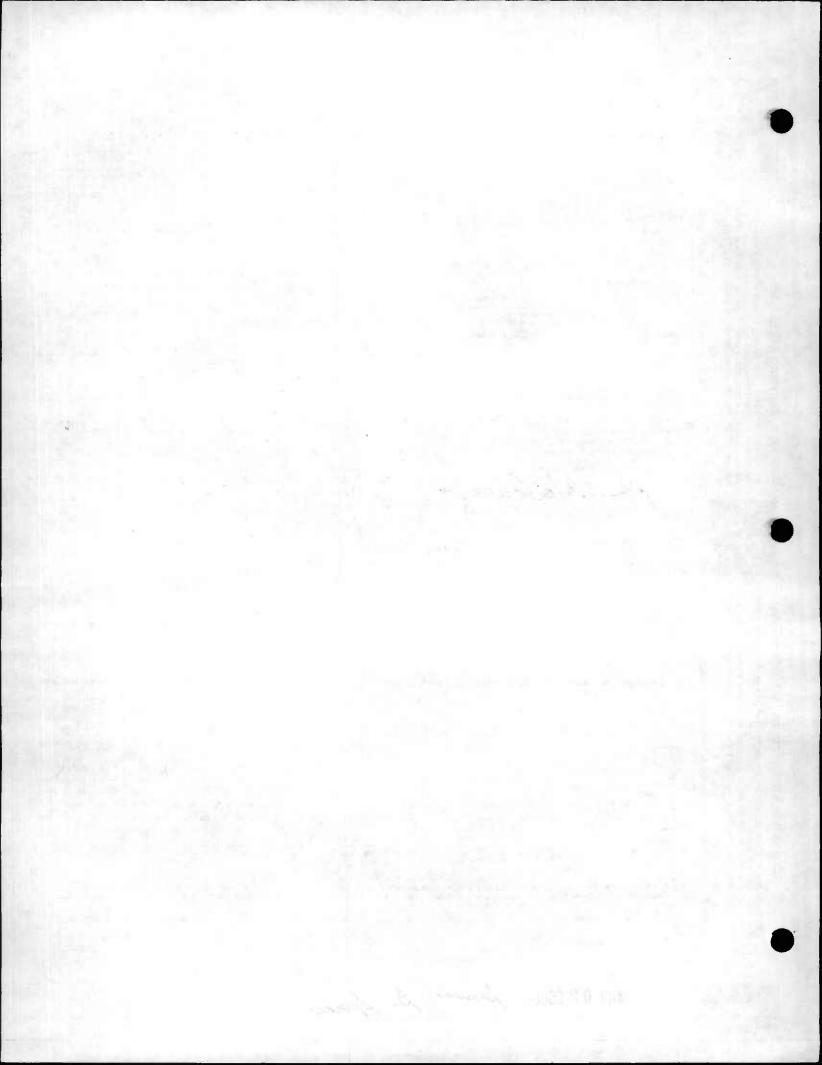
State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician GWENDOLYN** E CHRISTIAN April 5:06 AM 28, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1704 Glen Ave Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Deys 1 M 2 XF Yrs Director 222-18-5034 66 November 3,1933 Delaware **Usual Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No 28a-fi Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 8 6 must b 1704 Glen Ave 21804 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hyglene. Importanti if them 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed . Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Secretarial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 89 Raymond Bailey Pearl Wright 19e. Informent's Name/Relationship (Type, Print) 19b. Maiting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Robert J. Christian/Husband 1704 Glen Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Salisbury Crematory 4/28/00 Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Lice 22. Name end Addrass of Fecility Holloway Funeral Home Professional Association owa 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part. Enter the disease, or complications that caused shock, or heart feiture. List only one cause on with line death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intarval Batween Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical cur ar Lung Examiner Due to (or as a consequence of): Physician/Medical Examiner ahial Fibrillation The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury Due to (or as a consequence ot): P.O. Box 68760, Anemia that initiated events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detact 1 Yes 2 No 3 Probably 4 □ Unknown Records, à 24b. Were eutopsy findings eveilable prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? 2 No 1 ☐ Yes 2 No certificate 1 Yes of Vital To the Hospital or Attending Physician: Within 24 hours after death.

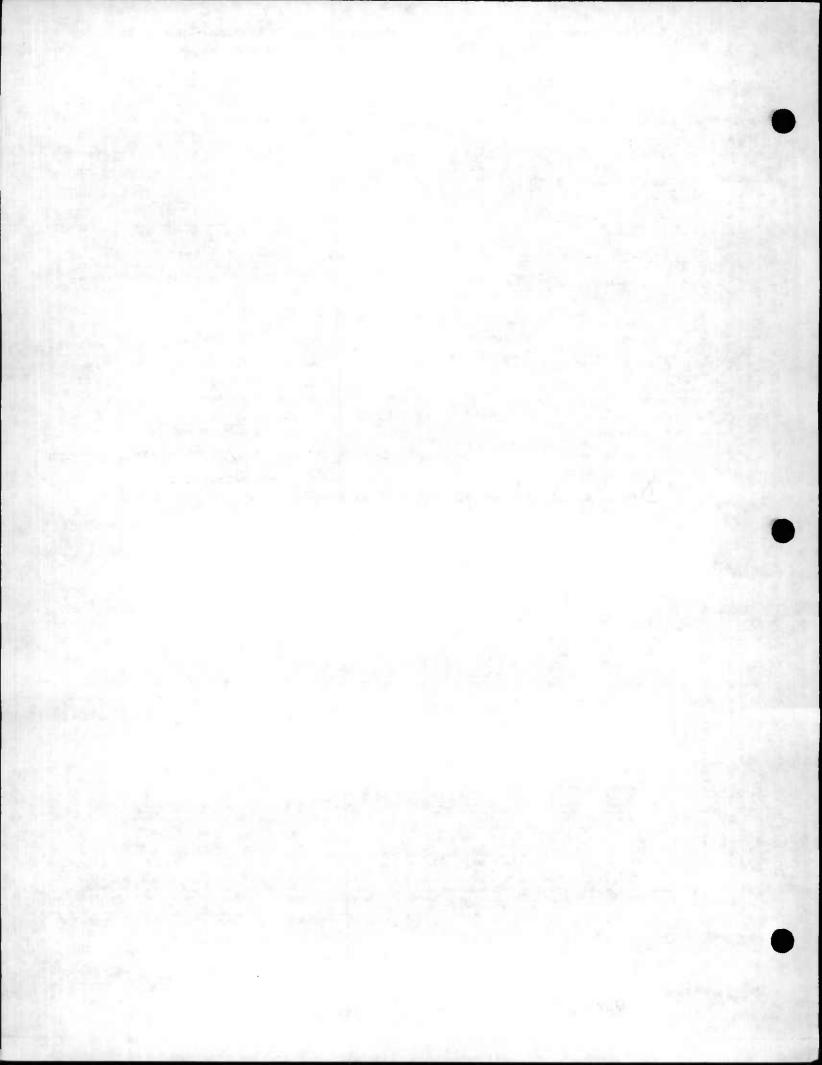
To the Funeral Director: After this certifica completely filled in by the funeral director; E 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpalient 3 DOA Other: 4 Nursing Home 5 Alesidence 6 Other (Specify) Certification: To 1☐ Yes 2♥ No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury et Work? Division 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be detarmined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Noterifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 047094 4/28700 Natgun. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 NATESAN SALI SBURY JTREET MILFURD 31. Date filed (Manth Sey, Co2) 2000 32. Registrar's Signatura State Registrar



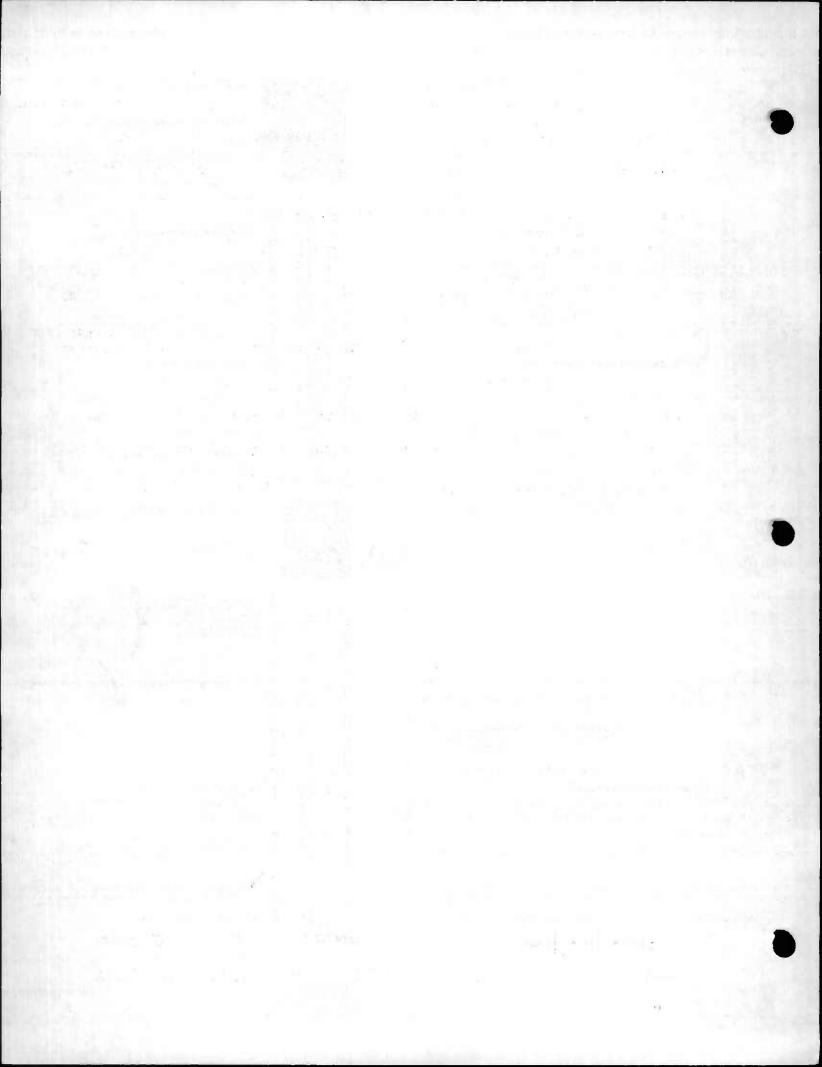
State of Maryland / Department of Health and Mental Hygiene

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3	17. Fathar's Nama (First, Middle	, Last)		18. Mother's Name (First, Middla, Maiden Sumeme)					ne)		
	Harry J. Down!	nam		Margaret Irwin							
•	19e. Informent's Name/Relation	ship (Type, Print)		19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code,						Code)	
	Margaret D. Edv		hter		Leeds Ro					4 1	
	20a. Method of Disposition	,	20b. P	lace of Dispo	sition (Neme of		Dete	20c. Location		own, State	
	1 ₺ Burlal 2 □ Cremation		Stete	emetery, crer	netory or other ple	-	1				
mportant: If tam 27 is marked other than "hatural, or lains 23s of 28s-1 show and in the must be notified at land. Ands. To Be Completed by Funeral Director	4 Donetion 5 Other (Che	erry Hill Methodist Cem 5/8/00 Cherry Hil					Hill,	Maryland	
	21. Signature of Funeral Service	Licensee		22	Name end Addre	ess of Fecility	nerale	DA			
	Daniel	2 N.	(20)						21021		
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximation of the provided in the cause of the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, interval interval.										
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	one) 2 Medical	Examiner: On the band mar	ner stated.	TOTI ATTOVOT IN	restigetion, in my	opinion, agen oc	Curred of the time	, овів впо рівсе	, end due t	o (ne cause(s)	
	29b. Signature end title of certific	et /		1	29c. Licen	se number		29d. Date sign	ed (Month,	Dey, Year)	
	4:11	Xa .	1 1.	L	1) 7	3.5	10	5	1-	177	
	1.40	orda	100		1/0			<u> </u>	T	00	
	30. Nema and address of person	who completed cau	se of death (Item		Print)	1. Di	1	/	1	1 197	
	limothy (DONNE	U VV,	6 3	L 520)	nes 14	8A 0	N60W	De	- / //	
9	31. Date filed (Month, Day, Year		Registrar's Signal	ture						,	
te ar		5 2000	Geneva	1	low	61				,	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 5 9 8 14 State of Maryland / Department of Health and Mental Hygiene

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Examin	ier	Residence: 336						Port De			4c. County	Ceci	1	
Funeral		5. Social Security Number	6. Sex 7. A		last birthday)	If Under 1		If Under 24 H	rs. R Date of I	Birth	,			te or Foreig
Director		431–62–6417 Usuel Residence of Decedent	1X M 2□ F	65	Yrs.	Months	Deys	Hours Mi	n. Jan.	31,	1935	Ar	kans	ate or Forei
8 1		10e. Stete 10b. County		10c. City	, Town or Lo	cation						10	d. Insid	le Clty Limi
	to	Maryland Cec	il			Port I	Оерс	sit					1 🗆	Yes XX
or 28	i e	10e. Street end Number				10f. Zip 0	Code			10g.	Citizen of V	Whet Count	try?	
23a	alE	336 Linton Run	Road				219	04			U.S	S.A.		
E III	Jue	11. Meritel Stetus	12. Wes Deceder Armed Forces	t Ever In U.	S. 13. V	Ves Decede	nt of H	Hispanic Origin? (Specify Yes or Noen, Mexican, Puerto Ricen, etc.)			No- 14. Rece - American Bleck, White, etc			n,
and Mentel Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	Be Completed by Funeral Director	1 ☐ Never Merried 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed TVDYes 2 If Yes, Give Yeer or Detes	}№ : 1958.		I□Yes 2							Specify: White	
oal E	8	15. Decedent	's Education	. 1750		ient's Usuel	Occup	ation	n 160		16b. Kind ot Business/Industry		ustrv	
Ned D	piet	(Specify only highes Elementery/Secondery (0-12)	t grade completed) College (1-4o	. 5 . \	(Give life. L	kind of work DO NOT use	done o	ation du <i>ring m</i> ost of w i)	rorking			r Corporatio		ation
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of Hy	Be (17. Fether's Neme (First, Middle, I						18. Mother's Neme (First, Middle,						
Ment arked	70	Ja	ake Dowler						Gert	rtie Mosby				44
and all		19e. Informent's Neme/Reletionsh								lumber, City or Town, Stete, Zip Code				
m 27		Evelyn W. Dowler	r (wife)	Total and					Port De					
or off		20e. Method of Disposition 1XXBuriel 2 ☐ Cremetion	3 □Removel trom State		lece of Dispo em <i>etery</i> , cren				Dete		. Location -			
tant:		4 ☐ Donetion 5 ☐ Other (Sp	pecify)	Hari	ord Mem				5/5/00	Ab	erdee	n, Ma	ryla	ind
Department of Heelth and Mentel Hyglene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Meone.		21. Signeture of Funerel Service L	licansee	л Sc.	L	ee A. F	att		Son Fun					
		23a. Pert1. Enter the disease, or shock, or heart teilure. List of	complications that cause	ed the deeth	n. Do not ente	erryvi erthe mode	of dyln	, Maryl	and Z lec or respiretory	errest.	3–0766		Approx	mete Between
nysician		Shock, or heart tellure. List of	only one cause on each	line.								i	Onset a	Between and Deeth
Medical		Immediate Cause (Final disease or condition		e	1.	1							1	
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ng physician end es the burlel-transit	Examiner	Sequentially list conditions,	Б.	Due to (or	r es e conseq	uence of):								
yan e	0	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury										İ		
shysic the b	dica	thet initiated events resulting in deeth) Lest	C	Due to (or	es e conseq	uence of):								
ding p	Physician/Medical		d											
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9 9	ysi	Pert II. Other significant condition	ns contributing to death	but not resu	alting in the ur	nderlying ca	use giv	en in Pert I.			cco use co			
2 4									_ 1!] Yes	2□ No	3 Prob	ably	Unkno
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s been signed by the ettending physician end should be deteched for use es the buriel-transit	leted b								-					2 □ No
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ate hes t	Be Completed	25. Wes cese reterred to medicel examiner? □ Yes 2 □ 100	Hospitel:	lent 201	EP/Outpetien	3□ 004	Oth	A.F.	eeth (Check on	y one)				
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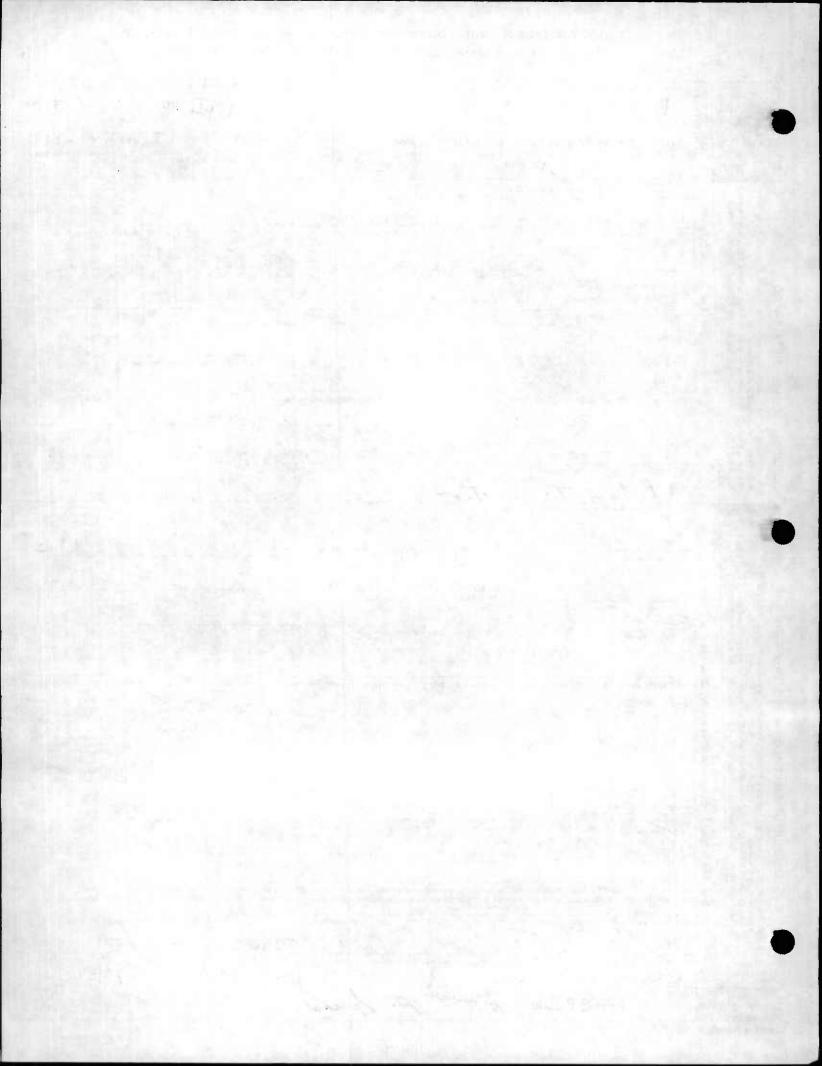


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev 9:41 pm **Physician** Robert DOYMAN 20 00 /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of 4c. County of Death Examiner Medical System

7. Age (In yrs. last birthdey) Baltimore of Mary land Raltmere If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) H Under 1 Year Birthplace (Steta or Foreign Country) 5. Social Security Number 6. Sex **Euneral** Deys Months 12M 2DF Director 222-18-9245 67 APR 11, DELAWARE Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nerns 23s or 28s-f show traumatic avant, the Medical Examiner must be notified at 1 Yes 2X No Director DELAWARE SUSSEX DAGSBORO 10f. Zip Code 10g, Citizan of What Country? 10e. Street and Number PINEY NECK ROAD 19939 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Meritel Status permit. Pages 1 and 2 should be filed within 72 hours after a Important: If them 27 Is marked other than "natural", or hen any Injury or other traumatic avant, the Medical Emeripance. 1 X Yes 2 No
If Yas, Give
Yeer or Detes: 1952-56 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 Nidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER 12 CONSTRUCTION EQUIPMENT 17. Felher's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be CHARLES ROBERT DORMAN LURENA STEELMAN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) ROBERT L. DORMAN, JR. / SON R.D. 3 BOX 212 B, MILLSBORO, DELAWARE 19966 aitimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) DAGSBORO REDMANS CEMETERY 4/25/00 DAGSBORO, DELAWARE 21. Signetura of Funeral Service Licensee 22. Name end Address of Fecility WATSON FUNERAL HOME, INC. alson 211 WASHINGTON STREET, MILLSBORO, DE 19966 Approximeta Interval Between Onsat and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrast, shock, or heart feiture. List only one ceusa on each line. **Physician** /Medical Immediate Cause (Final ohRS Multiple organ diseese or condition resulting in death) Examiner Examiner Colu Schemic The law requires that the deeth certificate be executed buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Lest Due to (or es e consequence of): pue physician s the burief Box 68760 Physician/Medical Due to (or es e consequence of): for use P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by i 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? page 2 should Completed this certificate has 1 Yes 2 No 1 Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Pleca of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Medical Certification: To 1 Yes 2 No funerel 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury et Work? 28d. Describe how injury occurred After Division Attending Natural 5 Panding investigation spital or Attenditions after deeth. deeth. 1 Yas 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 I Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled i Lettifying Physician: To the bast of my knowledga, daath occurred at the tima, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Media Gavin HENRY, ma Univ. 31. Dete filed (Month, Dey, Year) APR 2 8 32. Redistrer's Signature State 2000 Registrar



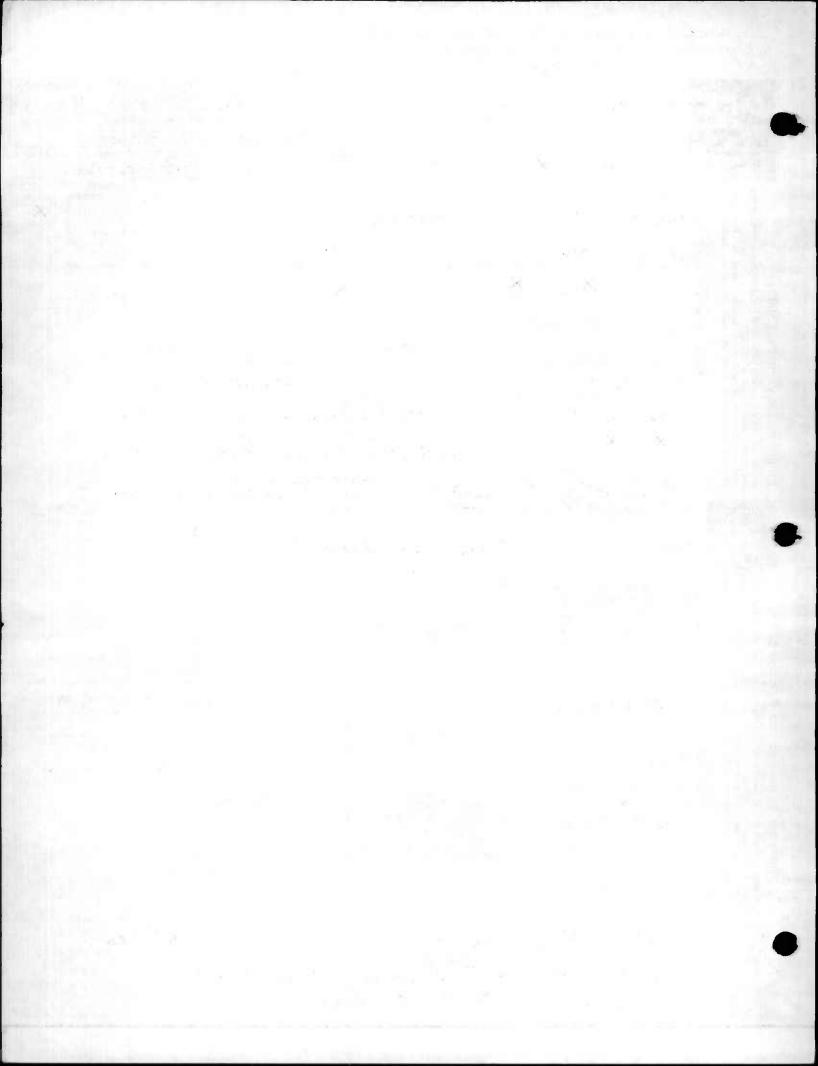
State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth April **Physician** 29" Malachi Deal 2000 1630 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner East Road Salisbury Wicomico Hours Min. 8. Date of Birth (Month, Dey, Ye Aug. 20 1 If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Deys Months M 2 F 1933 214-30-8100 66 Director Maryland Usuel Residence of Decedent death with the Maryland 10a, Stete 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 824 East Road 21801 Funerai U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 □ No If Yes, Give Yeer or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) al Hygiene. College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other th any Inlury or other traumatic event, the ance. 10 Laborer None 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McKinley Deal 2 Georgianna Cropper 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 824 East Road Salisbury, Md. 21801 Essie M.Deal (Wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town State Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 6/00 Springhill Mem.Garden Hebron, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Stewart Funeral Home 821 West Rd.Salisbury, Md.21801 23a. Part1. Enter the diseese, or compile shock, or heert feilure. List only or plications that caused be come. Do not enter the mode of dylng, such as cerdiac or respiretory errest, one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Accident Cerebrovascular Examiner Due to (or es e consequence of): Physician/Medical Examiner Hypertension The law requires that the death certificate be executed the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury and Due to (or es e consequence of): Records, P.O. Box 68760. thet Initieted events resulting In death) Lest Due to (or es e consequence of) use es t Po Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. detached 23b. Did tobecco uee contribute to the cause of deeth? 3 1 Yee 2 No 3 Probably 4 Unknown Alcahil abuce þ 9 24b. Were eutopsy findings eveileble prior to page 2 should Completed 24e. Wes en eutopsy completion of ceuse of deeth? this certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To To the Hospital or Attanding Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide to Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner stated. 29a, Certifier Medicai 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 2000 5 alc 30. Name and address of person who completed cause of death, tem 23e) (Type, Print) H. Latter Stephen Nanticoke MD 21840 MO PO Box 121 31. Date filed (Month, Dey, Yeer) 32. Redistrar's Signature State

Registrar

MAY 0 2 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

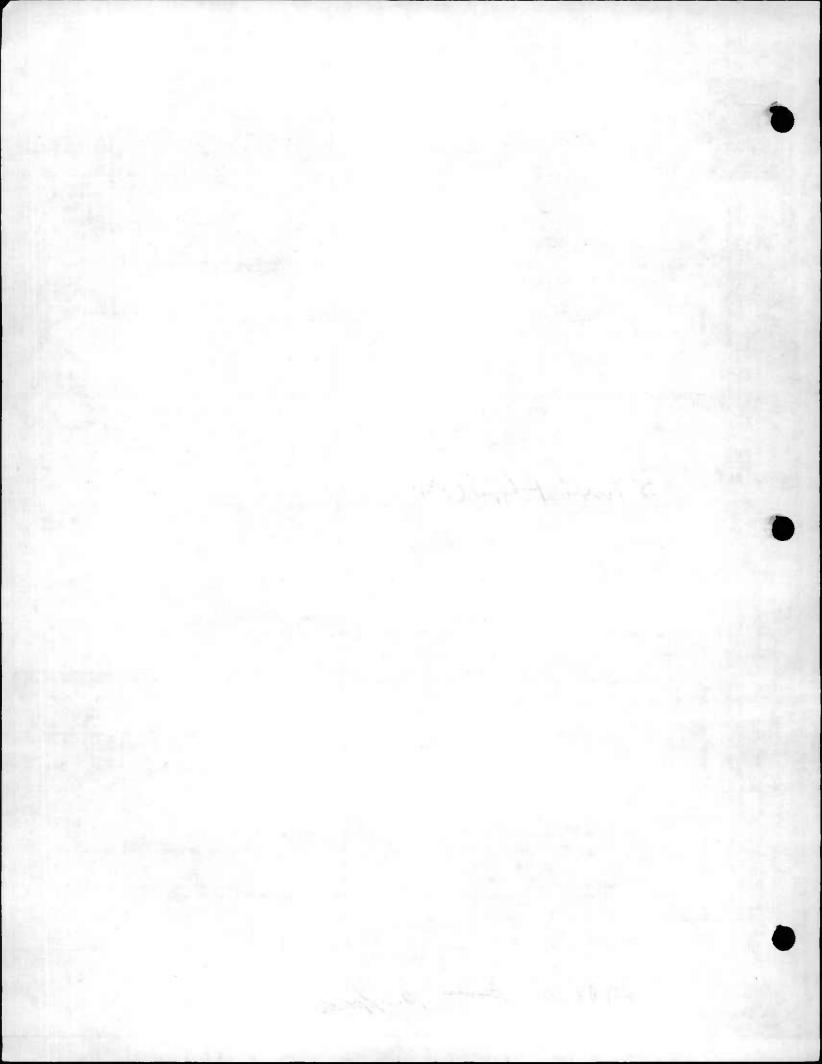
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Yaar **Physician** 4b. City, Town, or Location of Death DELLINGER , JR ROBERT **OSBORNE** 28 2000 900 /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 28, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 1∭ M 2□ F Yrs 79 Director 237-12-0307 1920 NORTH CAROLINA Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show 1 X Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10g. Citizan of What Country? 508 DRUID HILL AVE. 21801 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Depertment of Health and Mentel Hygiene. Important: if item 27 fa marked other than "natural", or hen any injury or other traumatic avent, the Medical Exempes Pages 1 and 2 should be filed within 72 hours after on the Health and Mentel Hygiene.
nt: if item 27 is marked other than "natural", or ite 1 Yes 2 No WWII
If Yes, Give
Year or Dates: MARINES 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN 3M OFFICE SUPPLY CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT DELLINGER, SR. BERTHA GLENN MURDOCK 19a. Informant's Name/Ralationship (Type, Print) PERS. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. RICHARD PATTERSON - REP. 3705 MUD LICK RD, S.W. ROANOKE, VA 24018 20b. Place of Disposition (Name of cametary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) WICOMICO MEMORIAL PARK 5/5/00 SALISBURY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 705 E. MAIN ST. SALISBURY, MD 21804 SP BOUNDS FUNERAL HOME, INC. 23a. Part1. Entar the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach line. Approximate Intarval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical Examiner to for as a consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed for usa as the burial-tran Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaase or injury Due to (or as a consequence of): P.O. Box 68760, lmic that initiated events resulting In death) Last Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, ğ 2 24b. Were autopsy findings available prior to page 2 should Completed 24a. Was an autopsy peed complation of ceuse of death? 2200 1 □ Yas 2 PNo certificate 1 Yes Division of Vital Attending Physician: funeral director. Be 25. Was cese referred to medical 26. Place of Death (Check only ona) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 25 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After Natural 5 Pending after death. 1 Yes 2 No 2 Accidant investigation the 6 Could not be datarmined To the Hospital or Atterwithin 24 hours after dei To the Funeral Directo completely filled in by th 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiar Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28 RO 114 VK and address of person who completed ceuse of death (Item 23a) (Type, Print) Shore An Salisbury MU 400 Eastern mio.

DHMH 16 Rev 6/95

Registrar

Spert DENKINGE

32. Registrar's Signature



Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or hama 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at pince.

Physician Medical Examiner

Baltimore, Maryland 21215-0020

	State of Man			e of Deat			g. No.		
. Decedent's Nama (First, Middla, Las	1)		W I	1		2. Data of Deat Month	h Day	Year 3. Ti	me of Death
Joseph Al	bert t	-uev	ster		201	MAY	44 -		2100
Facility Name (If not institution, giva		7/11	01	1		ocation of Death	4c. County	of Death	
1553 SAINT			Rd.	. /	UNI		/.	+H-	
Social Sacurity Number 214-44-6384 Sual Residence of Decedent	ax 7. Afga (A Min 2□ F	In yrs. last birthday	y) If Under Months	Days Hours	dar 24 Hrs. s Min.	8. Data of Birth (Month, Dey, SEPT. 1		9. Birthplace (S Country) B MARYLA	
Da. Stata 10b. County	10	Oc. City, Town or I	Location						ide City Limits
MARYLAND ANNE A	RUNDEL	ANNAPOLI	ıs					1 [Yas 2XXVo
De. Street and Number			10f. Zip			1	0g. Citizen of V		
1553 SAINT MARGAR	ETS ROAD			21401			U.S.	Α.	
1. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eva Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:	ır in U,S. 13	if Yas, speci	cify Cuban, Maxic	can, Puarto	pecify Yas or No- o Rican, atc.)		e - Amarican Indi kk, Whita, atc.	
15. Decedent's Edu (Specify only highest grad	ucation da complatad) Collega (1-4or 5+)	16a. Dec (Giv lifa.	edant's Usual va kind of work DO NOT use	al Occupation rk done during m sa retired)	ost of worl	king	16b. Kind of Bu	usinass/Industry	L. Fr
12		OWN	NER/OPE		000		AUTOM		
7. Fathar's Nama (First, Middla, Last) OTTO E.	FT	JERSTENBE	PDC.		thar's Nam	na <i>(First, Middl</i> a, M		e) MISKELLY	,
9e. Informant's Name/Ralationship (T						RET ral Routa Number			
JUDY ANNE FUERSTE		20b. Placa of Disp		na of	-	ROAD, AN		City or Town, Sta	
	Ramoval from Stata See Silver State Silver State caused the one cause on each line. a. Acut	20b. Place of Discomatery, or GLEN HAN	position (Namerematory or other VEN MEN 22. Nameremator) 1 SECON International Control of the Men 20 Men 2	na of ther place) MORIAL F d Address of Fac ND AVENU	PARK SINGLE, S.	/9/2000 NGLETON I	20c. Location - GLEN BUI FUNERAL N BURNI	City or Town, Sta RNIE, MI HOME, F E, MD. 2	ata D. P.A.,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

DHMH 16 Rev 6/95

29b. Signatura and titla of cartifia

ones,mo 31. Data filed (Month, Day, Year)
MAY 1 8 2000

32. Registrar's Signetura

ausa of death (Itam 23a) (Type, Print)

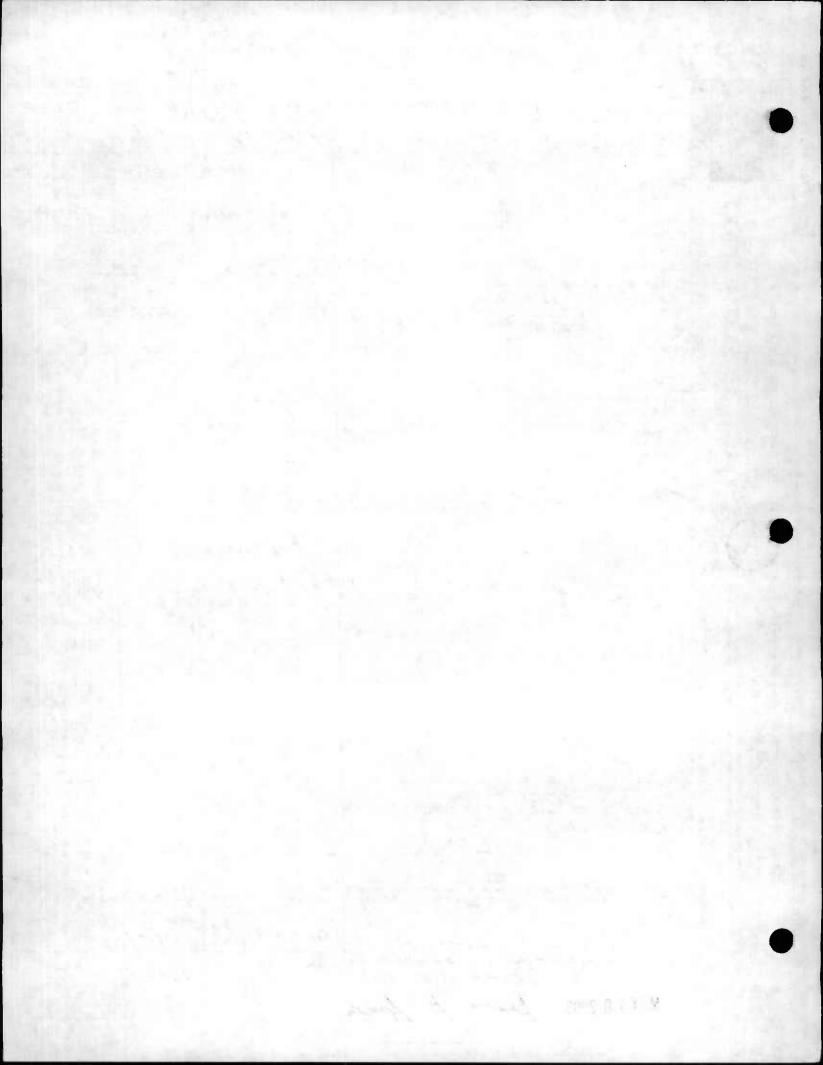
Deputy

29c. License number

D06054

America

29d. Data signad (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 61650r Month Year Alice APRIL 24 1000 2500 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 25, 1944 Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 200 F 217-42-6134 Yrs. 55 **Usual Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 28683 Ocean Gateway 21801 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 X Merried 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Cleamon Cephas, Sr. Ada Jackson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 28683 Ocean Gateway, Salisbury, MD 21801 Wavie Gibson, Jr./husband 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Green Acres Mem Park 4/29/2000 Salisbury, MD 21. Signature of Fundral Service Elbense 22. Name end Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Pert1. Enter the disease, or compile shock, or heart leiture. List only one effications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) 3 VS Due to (or as e consequence of) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy lindings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menper of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 2 Neturat 2 Accident 5 Pending 1 TYes 2 No investigation

ettending physician and for use as the buriel-transit The law requires that the death certificate be executed 1 Records, P.O. Box 68760, certificate has been signed by the elinector, page 2 should be deteched in Vitai Attending Physician: of this death.

Physician

/Medical

Examiner

Director

Funeral

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B

Funeral

Director

ehow

tiem 27 is marked other than "natural", or itema 23a or 28a-f sho other treumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours affer to Department of Health and Mental Hyglene. Important if them 27 is marked other than "natural", or then any injury or other treumetic event

Physician

/Medical

Examiner

Physician/Medical Examiner

Completed by

8

Certification: To

edical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture and title of certifie

Baltimore, Maryland 21215-0020

Division To the Hospital or Attendiviting 24 hours effect death To the Funeral Director: A completely filled in by the f

15 36

State Registrar

6 Could not be determined

29c. License number 026278

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

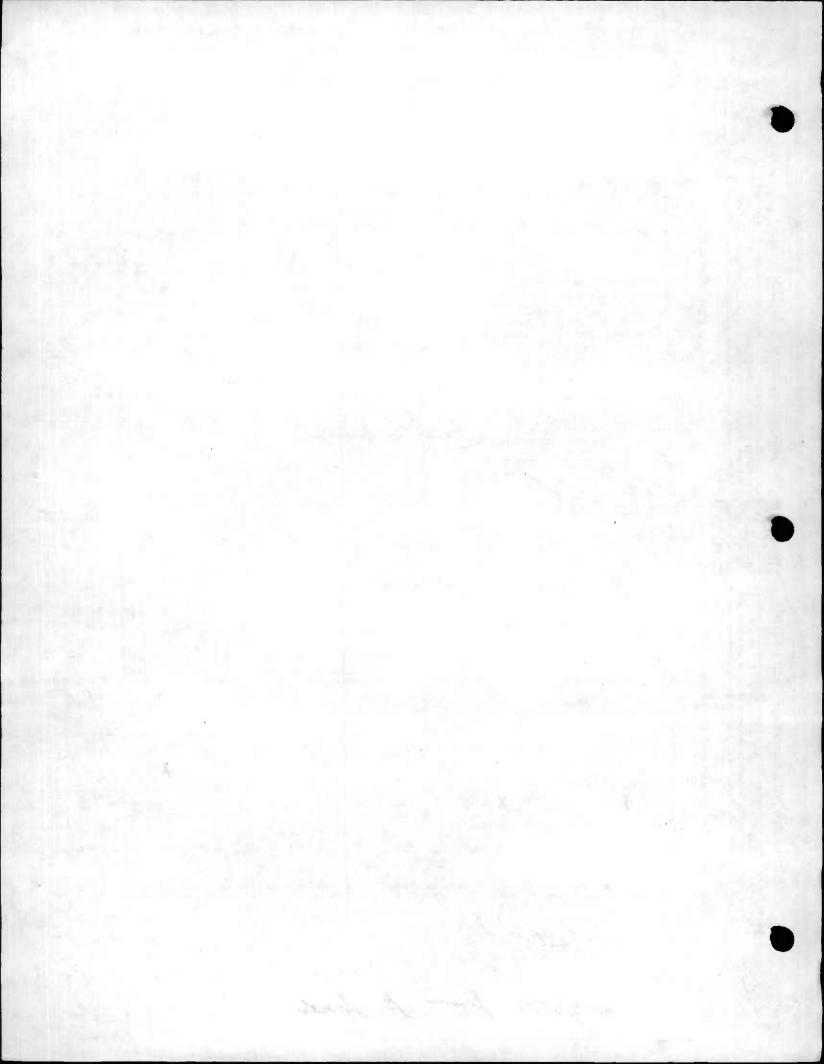
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OUA 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

APR 2 8 2000

CARROLL ST. SALISBURY, MD 21801

28e. Plece of Injury - At home, Jerm, street, Jactory, office building, etc. (Specify)



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death May 3, **Physician** Charles Luther Hawkins 2000 11:50 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 541 Chippingwood Drive Port Republic Calvert If Under 1 Yaar ff Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2□F Yrs. Director 40 1464 70 10 1930 North Carol Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Calvert Port Republic Director 28a-fa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 541 Chippingwood Drive 20676 United States natural, or flams 23s Funeral 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 2 ☐ No If Yes, Giva 5 Yaar or Datas: 1 ☐ Nevar Married 2√ Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16h Kind of Business/Industry Eiamentary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filled wh Department of Health and Mental Hygens Important; if Item 27 is merited other tha any injury or other treumeds sawmill lumberman 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Avery James Hawkins Mildred V. Pipes 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Lucy M. Hawkins- wife same as #10 20b. Placa of Disposition (Name of camatary, crematory or other placa May 6 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata
4 Donation 5 Other (Specify) 2000 Calvary Bible Cemetery Lusby Maryland 21. Signature of Funaral Sarvice Licansee 22. Nama and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximate 76 Interval Between 6 Onset and Death Physician fmmediata Causa (Final disaasa or condition rasulting in daath) /Medical CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Diseesa or injury and Dua to (or as a consequence of): Box 68760, attending physician for use as the buria that initiated avants resulting in death) Last Dua to (or as a consequence of): P.O. Part ff. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part I. 23b. Did toleacco use contribute to the cause of death? 3 Yes 2 No 3 Probably 4 Unknown signed b Records, þ Completed 24b. Ware autopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 No certificate 1 Yas 2 No Division of Vitai or Attending Physician: Be 25. Was case rafarred to medical 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this 27. Mannar of Death 28c. tnjury at Work? 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation - Natural 1 Yas 2 No death. 2 Accidant Director: 6 Could nof be datarmined 28a. Pleca of fnjury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) after 4 Homicide To the Hospital or within 24 hours aft. To the Funeral Direction completely filled in the Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, deeth occurred at tha tima, data and placa, and dua to the cause(s) and manner stated. 29e. Certifian 29b. Signature and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) mun May 4, 2000

State Registrar

DHMH 16 Rev 6/95

Prince Frederick, MD 20678

30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

MAY 0 5 2000 >

M.D.

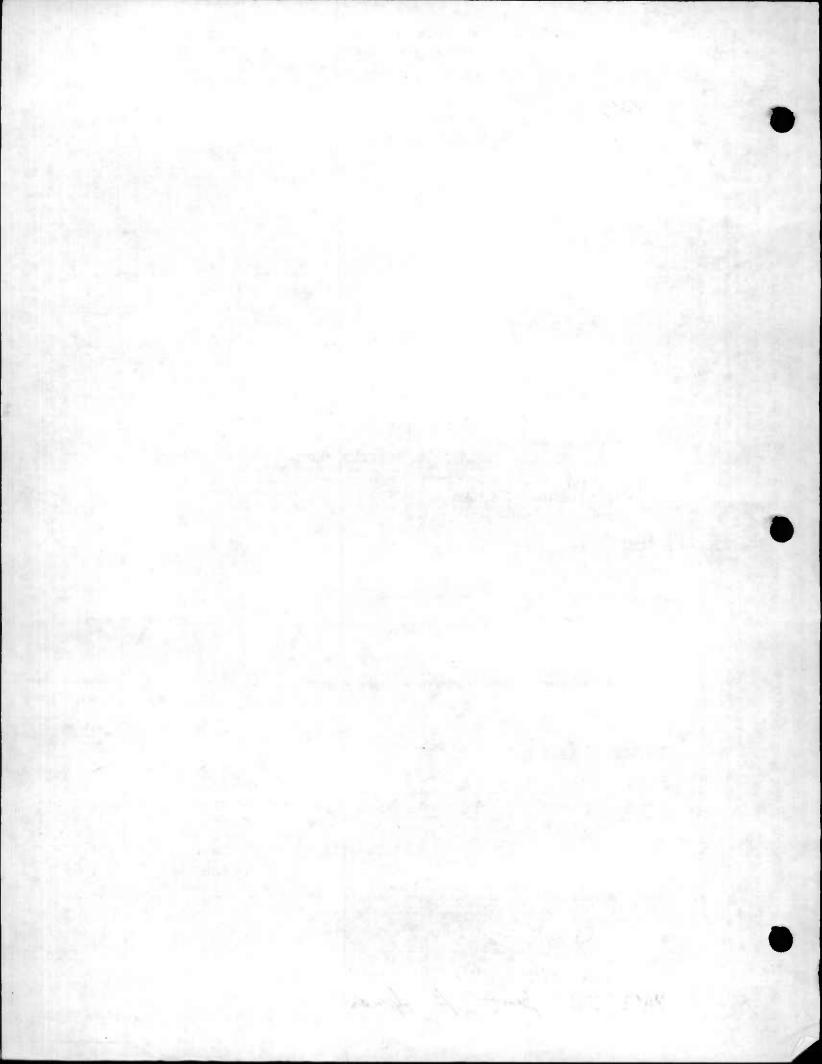
32. Registrade Signatura

Peter Wisnieski,

MAY 115 THE GRAND ST. ST. ST.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

-2664-025 rl Ellis Ho		PART I,	27, 28	ertificate of	Death 8-8	2. Data of Dee	-	3. Tima of Death		
Phyšician	1. Decedent's Name (First, Middle, Last) Carl Ellis Hoke						Day Yeer 11, 2000 1950 I			
/Medical/ Examiner کے	4a Facility Nama (If not institution, give street and number) T.AKE 4b. City, Town, or L.					MAY ecation of Death				
1	ACROSS FROM 1911 EDG			ERENE	EDGEWOOD If Under 24 Hrs.	9 Date of Birth	HARFORD			
Funeral . Director	5. Social Security Number 6. Sax 152 N Usual Rasidence of Decedant	2 T F	n yrs. last birth	Months Devs	Hours Min.	8. Data of Birth (Month, Day Aug. 29	, 1962 M	9. Birthplaca (Stata or Foreig Country) Iaryland	gn —	
how how	10a. Stata 10b. County 10c. City, Town or Location							10d. Inside City Limit		
with the Manyland a or 28s-f show to notified at	Maryland Harford Joppa						1 ☐ Yas			
ith with the Maryla 23a or 28a-f sho ust be notified ral Director	10e. Street and Number									
of the death with the the the the the the the the the t	611 Dembytown Road	Was Decedant Eva	r in U,S.	21085 13. Was Decedant of I If Yes, specify Cub	Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race	- Amarican Indian,		
	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 Yas 2 No If Yes, Giva Yaar or Dates:	No 1 ☐ Yas 2 ☐ No Specify:			Hican, atc.)	Whita, etc. Black			
1 21215-002 ed within 72 hours ygiens a ygiens a ygiens ygiens ygiens t, m. Med all Exe ft, m. Med all Exe Completed by	15. Decedant's Educat (Specify only highast grada of	ion omplated)	16a. C	ecedent's Usual Occup Giva kind of work dona ife. DO NOT use retire	pation during most of work	ing	16b. Kind of Bus	iness/Industry	17)	
within within then the west	Elementery/Secondary (0-12)	Collega (1-4or 5+)		et Install			Potail	Carnot		
	17. Father's Nema (First, Middla, Last)		Car	et mstar.		Retail Carpet ma (First, Middla, Maidan Surname)				
Maryland d2 should be file th and Mental Hy 71s marked other traumatic avent To Be C	Dennis Austin Hoke,	Sr.		170	Ruth Est	her Tur	ner			
Mar 12 sh h and 18 m	19e. Informent's Neme/Ralationship (Type,	, Print)		Mailing Addrass (Strae				tate, Zip Code)		
Baltimore, Noemit, Pages I and Department of Health Important: If I item 27 I any Injury or other tr. once.	Gloria Louise Hoke 20a. Method of Disposition	/ Sister	Ob. Place of C	5 Longwood Disposition (Nama of	T	Wood, M		City or Town, Stata		
Baltimore, semit. Pages 1 a Department of Hes moorlant: If item iny Injury or other size.	1 ☐ Burial 2 【Cramation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)			crematory or other pla		16 00		and the same of		
Baltimoperation Page Department Important: I any Injury of Diffe.	21: Signatura of Funeral Service Licensee	^	HIIICO	Service (22. Name end Addre	ess of Facility		TOWSOIL,	Maryland		
0 88 E 8 8	Helly Morna	Renn	woods	McComas Fi			don MD	21009		
	23a. Part1. Enter/fre disease, or complicat shock, or heart allure. List only one	tions that caused the cause on each line.	death Od no	t anter tha moda of dyi	ng, such as cardiac	or raspiratory er	est,	Approximate Intervel Between		
Physician /Medical	Immedieta Causa (Final		DROW	NING				Onsat and Death		
Examiner	diseasa or condition resulting in death) a.	Dur	- to /or or o	2000110000 04)					_	
Je Je		Du	e to (or es e co	nsequance of):						
58760, icate be axecuted physician and s the burial-transit	Sequentially fist conditions,									
	Sequentially fist conditions, if any, laading to Immediate cause. Entar Underlying Cause (Disease or injury that initiated evants Due to (or as a consequence of):									
2 06 -	rasulting in daath) Last									
that the death cartified by the attending detached for use as Physician/Me	d									
	Part fl. Other significant conditions contrib	outing to death but n	ot resulting in t	he undarlying cause gi	ven in Part I.	23b. Did to	obacco use cont	ribute to the cause of deat	h?	
that that the detached by the detached y Phys			1 Yes 2 No 3 Probably			nwn				
O 8 2 2 0							24a. Was an eutopsy performed? 24b. Wara autopsy available		s	
ecord aw require as been si 2 should							med?	available prior to completion of cause of death?		
Vital Relations The law certificate has rector, page 2						1700	as 2 No	17 Yes 2□ No		
Division of Vital Rale of Attending Physician: The instance of Marchis certificate he din by the funeral director, page ertification: To Be Comertification:	25. Was casa refarred to medical exeminer?	na)								
- 5 w D	XXYas 2 No Hos		Homa 5 Rasidance XXIOthar (Specify) AT SC							
On Olling I	27. Mennar of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation investigation						28d. Dascribe how injury occurred			
Vision Attending In death. Sector: After by the fune	all a site of Could not be	5-11-00 5:57 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)				SUBJECT DROWNED 28f. Location (Street and Number or Rural Route Number,				
Div Dis after a safter 4 ☐ Homicida building, etc. (Specify) LAKE						in Lake serene, Harford Co. M				
Division of the Hospital or Attending Privilla 24 hours after death. To the Funeral Director. After this completely filled in by the funeral Medical Certification:	29a. Certifiar (Check only one) 1☐ Certifying Physici 2☑ Medical Examiner		aminetion and/							
To the within 2 To the comple	29b. Signeture end title of certifiar	11	7-1-4		sa number	29d. Data signad (Month,				
) M. CHE					MAY 12, 2000				
	30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) JACK M. TIUS, M.D. 111 Penn Street, Baltimore, Maryland 21201									
State	31. Dete tiled (Month, Day, Year) MAY 1 8 2000	2 32. Registrar's	Signatura	1	cer, ball	люте,	Har A Talk	21201		
Registrar	WHIT & SOON	any.	PI	sporks						

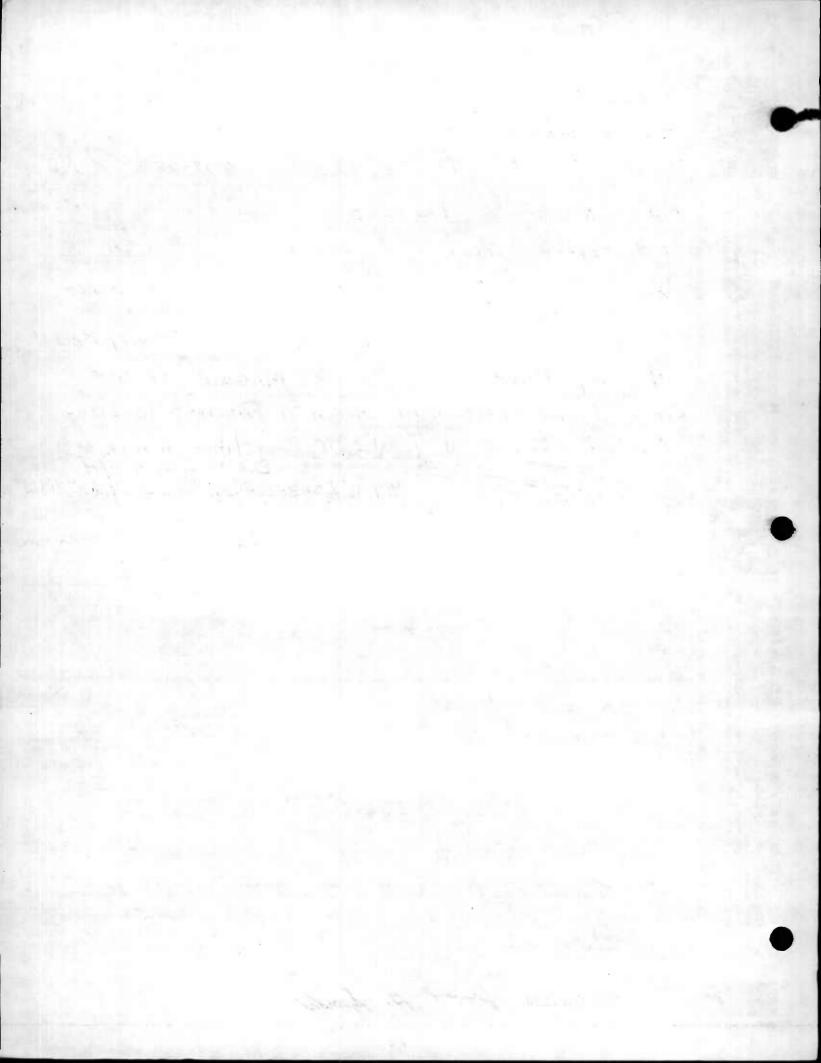


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death 430PM **Physician** Mary F. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 2-18-2 6 Sax Birthplaca (State or Foreign Country) **Funeral** Days 10 M 200 F 214-28-1389 Yrs Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MO FRUITLAND 1 Yes 2 No Funeral Director WICOMICO 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 109 -21826 permit. Pages 1 and 2 should be filed within 72 hours efter deeth v. Department of Health and Meniel Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a edge. "natural", or itema 23a STREET USA 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3⊠Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) PURITY BACON BAKER 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be ILEARY MAGGIE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 111-CHURC ELMER J. -RUITLAND, MD. ANNON-BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place 20e. Method of Disposition 1. Burial 2 Cremetion 3 Removel from State 5/1/2000 4 ☐ Donation 5 ☐ Other (Specify) EMETARY HURLOCK, MARYLAND VETERAN L SMITH 21. Signature of Funeral Service Liveral Neme and Address of Fecility BENNIE 917-W. ISABELLA SAUSBURY, MD. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one causa on aech lina. Approximete Intarvat Between Onset and Deatl **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical in Known Cardiomyopa Examiner Dua to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760, Due to (or as a consequence of) P.O. | Part II. Other significant conditions contributing to death but not resulting in tha undarlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy mellitus mpertension 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case raferred to medical examinar? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) completely filled in by 4 Homicide Le Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifian (Check only one) 29b. Signature and tipe of certifie 29c. License number 29d. Data signed (Month, Day, Year) 00 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) hartes B. Silvia 31. Dete filed (Month, Day, Year) MAY 0 1 2000 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3 Time of Death Dey **Physician** PAULINE LIVINGSTON HOLLOWAY May 1, 2000 5:10 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** WATERVIEW HEALTHCARE CENTER SALISBURY WICOMICO If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) March 8,1914 7. Age (In yrs. lest birthday) **Funeral** Birthplece (State or Foreign Country) Deys Months Hours 1 M 2 XF 86 Yrs. Director 214-10-8506 Maryland Usual Residence of Decadent 10e. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho Wicomico Maryland Salisbury 1 ☐ Yes 2 No Directo 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 3343 St. Lukes Road 21804 USA deeth Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Detes: 21215-0020 1 ☐ Yes 2K No Specify: White þ Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Bookkeeper Motel traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be h and Mental t Peges 1 and 2 should be Lee Roy Livingston Antionette Brown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) of Health a Rodney F. Holloway/Son 3343 St. Lukes Rd., Salisbury, MD 21804 other 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete permit. Peges
Department of
Important: If It
any Injury or o O 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Union Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/4/00 Salisbury, MD 21. Signature of Europea Servica Licenses 22. Name end Address of Fecility Holloway Funeral Home Professional Association 17. Enter the disease, or complications that caused the ck, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximete intervel Between Onset end Deeth eeth. Do not enter the mode of dying, such es cardiec or respiratory erres **Physician** immedlete Ceuse (Finel disease or condition resulting in deeth) /Medical Lemenha Examiner Due to (or es e consequenca of): Physician/Medical Examiner CVA The law requires that the death certificate be executed use as the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of): P.O. Box 68760, ettending physiclan DW Due to (or es e consequence of): resulting in death) Lest ASCUD for Pert ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, ٥ should be 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed's hes page 2 1 Yes 2 No 1 ☐ Yes 2 No of Vital or Attending Physician: director. 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 28c. Injury et Work? 27. Manner of Deeth Dete of injury (Month, Dey Year) Aftert Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Neturei 5 Pending Investigation s efter death.
I Director: Aff 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled is 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 5/2/00 WHENN D47094 30. Name end eddress of person who completed cause of death (item 23e) (Type, Print) SALUSBURY, ND 21804 NATESAN 106 MILFORD STPEET

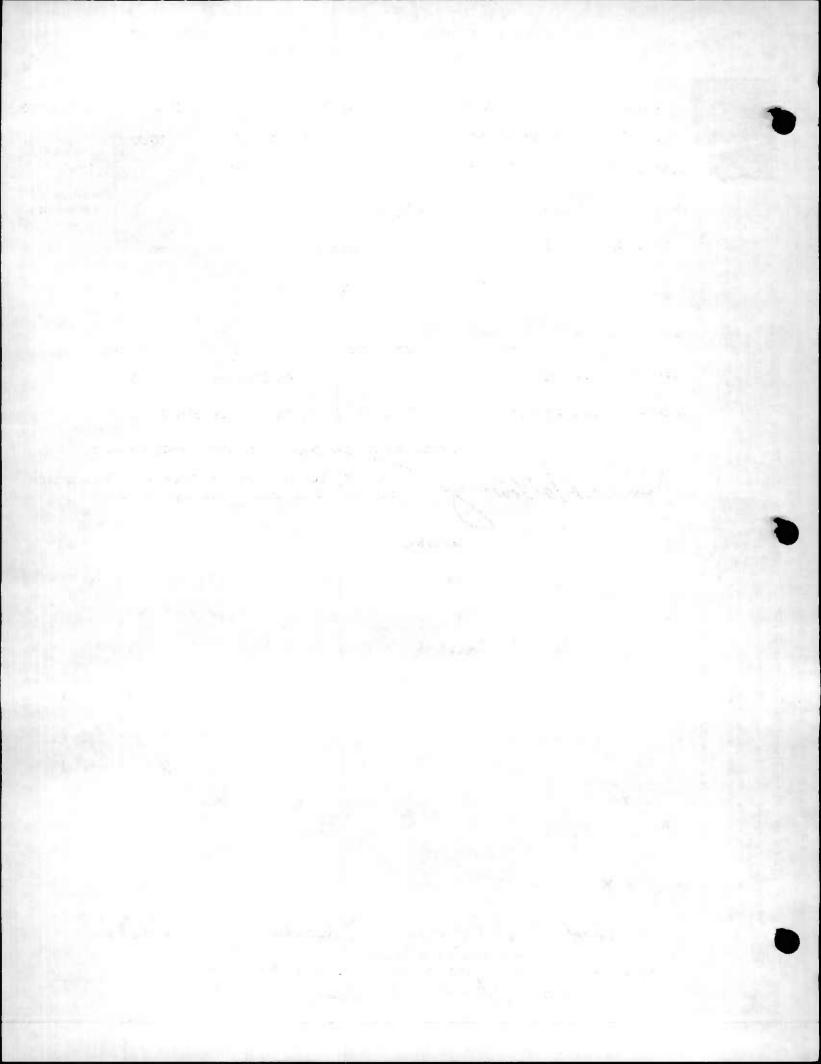
Registrar

State

May 03 2000

31. Dete filed (Month,

32. Regionar's Signature



Piease Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** KATHERINE 2000 HANCOCK April 29, MILLER 6:58 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 796 Terrie Court Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Day, Year)
April 30,1915

9. Birthplace (Stete or Fore Country)
Pennsylvania Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 □ M 2 □ F Yrs. 158-10-3001 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or forms 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Wicomico Salisbury Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 796 Terrie Court 21801 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hyglene. Important if item 27 is marked other than "natural", or handle project of the contrast o Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ho f Yes, Give Yeer or Dates: Specify: Specify: 2 White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Steven Miller Anna Sipos 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia H. Malone/Daughter 509 Tony Tank Lane, Salisbury, MD 21801 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremetion 3 Removel from Stete 5/2/00 Parsons Cemetery Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatured Funeral Service Licensee 22. Name and Address of Facility MOIOSI Holloway Funeral Home Professional Association blompoor 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cerebit Variabra accident Examiner Physician/Medical Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Box 68760. white attending p US0 88 Records, P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings evailable prior to Completed 24a. Wes an autopsy completion of cause of death? this certificate 1 Tes 1 ☐ Yes 2 ☐ No Division of Vitai Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident To the Hospital or Atta within 24 hours aftar de To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide time of the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Jose

EASTERN Shore DR. SAlisbury, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BADROS

813B

Registrar's Signeture

Chapter Combined photosis of the Months of t

2.31 2.52. DISIDS 5/1/00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARTHA JONES MAY 6, 2000 23:34 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth (Month, Day, Year) Feb. 12, 1932 ff Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) Maryland 7. Age (In yrs, lest birthday) **Funeral** 1□M 2XF Months Days Hours 215-62-9747 Yrs. Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show tem 27 is marked other than "natural", or ferms 23a or 28a-f show other traumatic event, the Medical Examiner near the political at 1 ☐ Yes 2 No Directo Owings Calvert Maryland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20736 385 Skinners Turn Road deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Meritel Stetus filed within 72 hours efter Hygiene. other than "natural", or ite Specify: Black 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bualness/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Housewife Own Home permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Rawlings Wallace Grant 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Owings, MD 20736 385 Skinners Turn Rd. Cindy Jones/Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State 5/11/00 Huntingtown, MD 4 □ Donation 5 □ Other (Specify) Patuxent UM Church Cem. 22. Neme end Address of Fecility Sewell Funeral Home 21. Signeture of Funeral Service Licensee 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last attending physician and for use as the burial-tren P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 Yes 2 No 3 Probably Unknown Records, þ 24b. Were autopsy tindings evailable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? B 26. Place of Death (Check only one) Hospitel: Hopatient 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? After Neturel 5 Pending investigation n 24 hours after deeth. 1 Yes 2 No 2 ☐ Accident

State

Hospital

To the Hosp within 24 ho To the Fune completely fi

Registrar DHMH 16 Rev 6/95

6 Could not be determined

DR DAVID GALLATIN, MD

MAY 0 9 2000

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one) 29b. Signeture end title of

30. Neme end add

31. Dete filed (Month, Dey, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

fical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

20678

29c. License number

Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

GALLADIN

person who completed cause of deeth (Item 23a) (Type, Print)
DAVID GALLATIN, MD PRINCE FREDERICK,

32. Registra/s Signeture

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

A from the spends

Piease Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death 40A **Physician** Eliven F. Johnson, Jr. 27 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sax Birthplaca (State or Foreign Country) **Funeral** 12 M 2 F Months Days Yrs 216-56-1702 Director July 8, 1952 MI Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location ahow 10b. County 10d. Inside City Limits 1 Ves 2 □ No MD Director Worcester Snow Hill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 419 S. Church St. 21863 U.S. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural', or Items 11 Marital Status 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 Hygiana. College (1-4or 5+) Heavy Equipment Operator City Government 17. Father's Neme (First, Middle, Last) parmit. Pagas 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 Is marked oth any Injury or other traumstic event potsa. 18. Mother's Name (First, Middle, Maiden Surname) Eliven F. Johnson, Sr. Hazel M. Forman 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaToya L. Johnson/daughter 413 Overbrook Dr., Salisbury, MD 21801 Baltimore. 20a. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete Friendship United

Methodist Church Cemetery5/3/2000 Snow Hill, MD 1 Buriel 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** 3 months Immediate Ceuse (Final disease or condition resulting in death) /Medical Circhosis Examiner Due to (or es e consequence of): alwholsom be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown mellitus Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 1 Tes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Aftar Division or Attending 1 Natural 2 Accident s after des. 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homloide To the Hospital c within 24 hours al To the Funeral D Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier 29b. Signeture end to certifier 29c. License number 29d. Date signed (Month, Day, Year) D30853 00

DHMH 16 Rev 6/95

Registrar

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PRMC

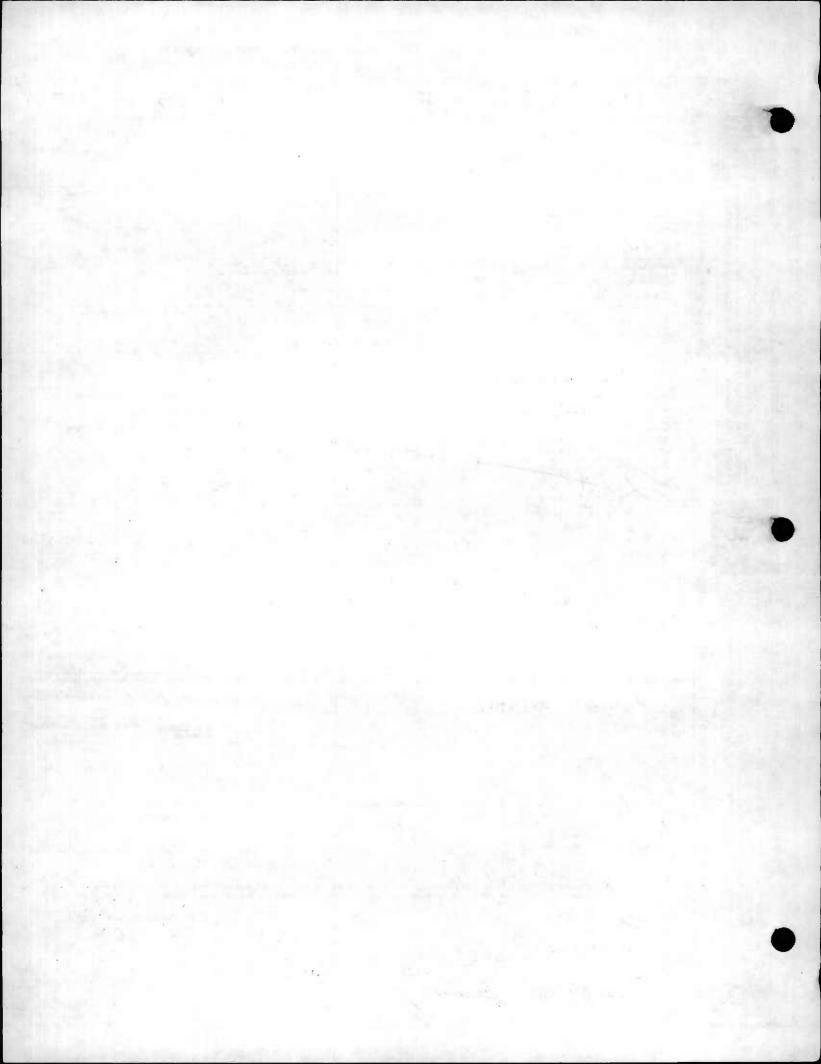
30. Name end address of person who completed causa of deeth (Item 23a) (Type, Print)

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31. Dete filed (McMADy, Oea2 2000

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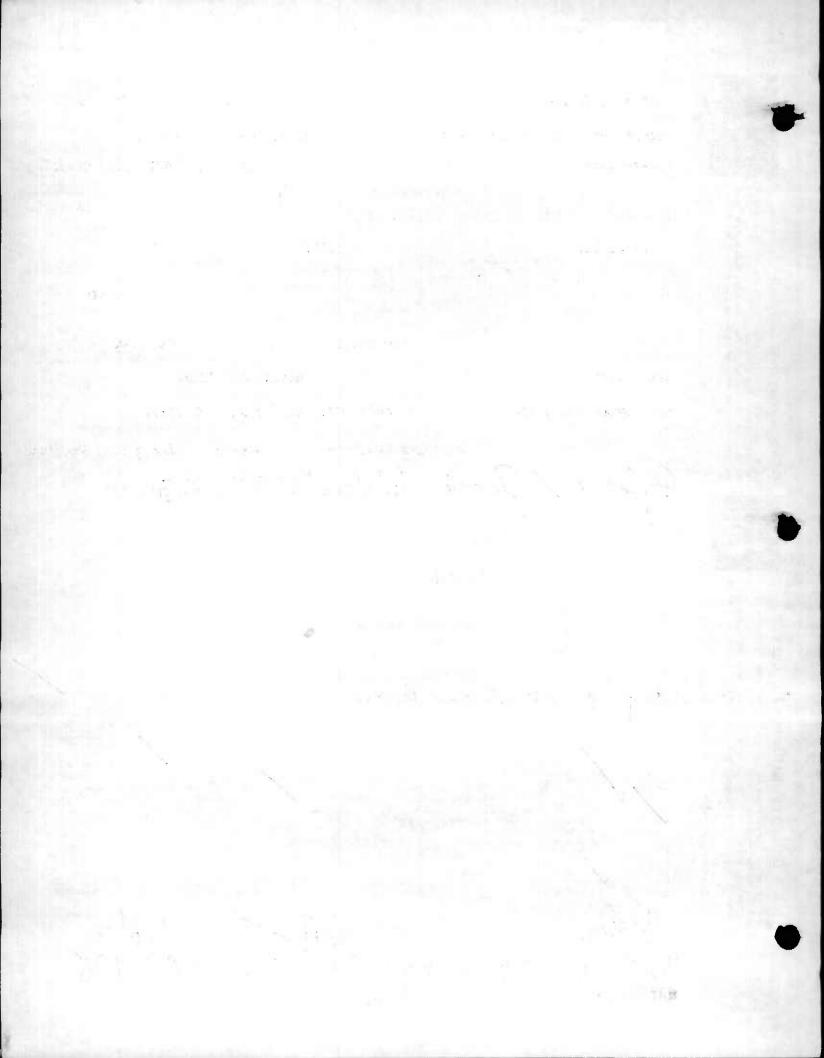
32. Redistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15997

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Physici	an	1. Decedent's Name (First, M						2. Date of Month 05		2000°	3. Time of Death	
/Medic		4a. Facility Name (If not institu		number)			4b. City. Tow	n, or Location of De		LUUU ity of Death	2200	
Examin	ier				ton							
uneral		Calvert Manor Healthcare 5. Social Security Number 6. Sex 7. Age			(In yrs. last birthday) If Under 1 Yee		reer If Under 2	Rising Sun		Cecil Birth 9. Birthplace (State or For		
irector		168-24-6345 Usual Residence of Deceden	1□ M 2□XF		92 Yrs.	Months D	Pays Hours	If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20, 1907 North (h"Caroline	
show		10a. State 10b. Cou	10c.	City, Town or Lo	ocation				1	IOd. Inside City Limit		
or items 23a or 28a-f		Maryland	Cecil	ecil Rising Sun							1 X Yes 2 □ N	
		10e. Street and Number				10f. Zip Co	ode		10g. Citizen o	f Whet Cour	ntry?	
		8 Louise Ct.	•				21911		USA			
		11. Marital Status	12. Was De	ecedent Ever in Forces? s 2 2 No	U,S. 13.	Was Deceden	t of Hispanic Orig	in? (Specify Yes or Puerto Ricen, etc.)		ace - Americ		
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Department of recent and when the important if them 27 is marked other than any injury or other traumatic event, the Monte.	Be (17. Father's Name (First, Mide	die, Last)				18. Mother	's Name (First, Midd	lie, Maiden Suma	ame)		
rrka atic	ည	Aaron Lyon					Mar	tha Ann A	dams			
E III		19a. Informant's Name/Releti	onship (Type, Print)		19b. Mailir	ng Address (S	treet and Number	or Rural Route Nur	ural Route Number, City or Town, State, Zip Code)			
er tr		Ruth Burton,	/Daughter		8 L	ouise (Ct., Ris	ing Sun,	MD 21911			
lten oth		20a. Method of Disposition 1 X Burlal 2 ☐ Cremeti	• FB	20b	. Place of Dispo cemetery, cren	sition (Name	of r place)	Date	20c. Locetion	n - City or To	own, State	
Ty o		4 Donation 5 Other		n State	sebank	-		5-9-00	Risiv	na Sun	, Marylar	
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any ir		6/1	14/1	1 . 1	R.	T. Foo	ard Fune	ral Home, , Rising	P. A.			
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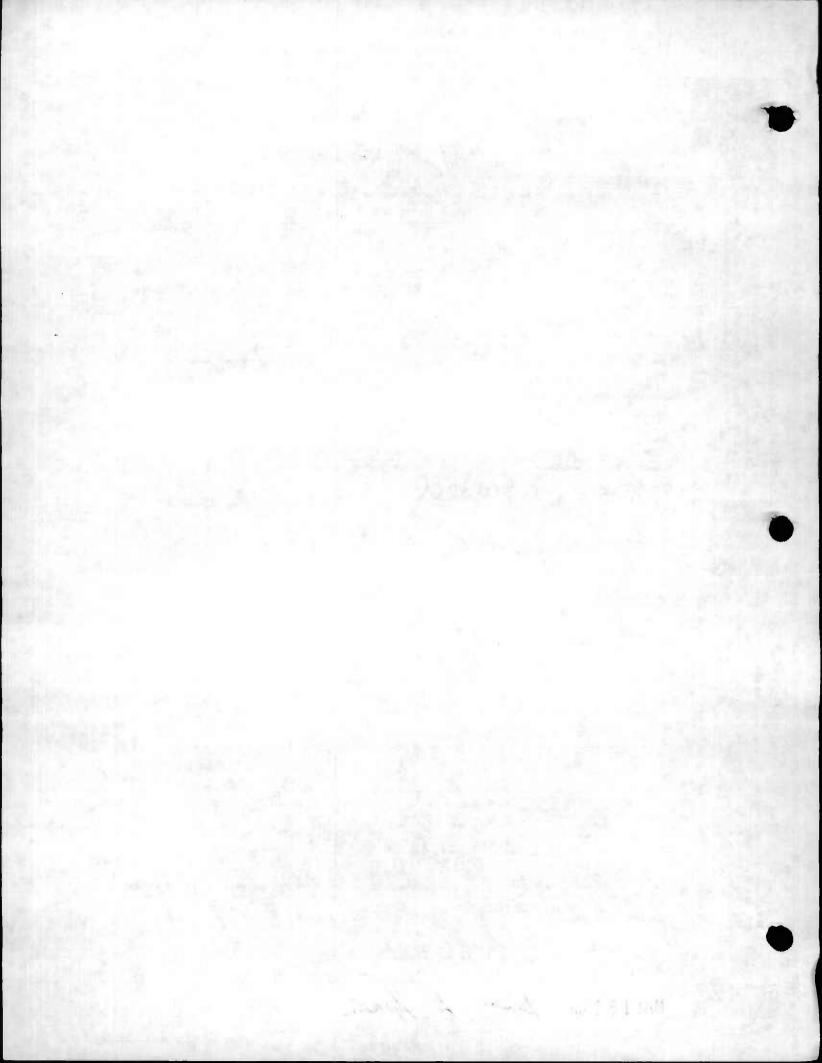


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ENT	March Service		C	ertificate o			g. No.		
Physician	1. Decedent's Name (First, Middle,			2. Date of Deat Month		3. Time of Death			
/Medical	Martha Durd			MAY 08		17:20 PM			
Examiner	4a Fecility Name (If not institution,	give street and number)			4b. City, Town, or	Location of Death	4c. County of I		
	2202 OLD COURT	ROAD		44	Brookla	ndville	BALTIM	ORF	
Funeral		6. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Yea		8. Date of Birth	9.	Birthplaca (State or Foreign Country)	
Director	587-56-3864 Usual Residence of Decedent	1 □ M 2 □ F	47 Yrs.	Months Day	s Hours Min.	March 2	Year) 1953	Greenwood, M	
end *	10a. State 10b. County 10c. City, Town or Location								
the Maryler 28a-f ahow cort et at	MD Balt:	ille			1 ☐ Yes 2 ☐ No				
offer death with the Maintenance 23s or 28s-1 and the must be notified. Furneral Director	10e. Street and Number 202 Old Court 1	10f. Zip Code 210		10	10g. Citizen of What Country? USA				
Urs ours	3 ☐ Widowed 4XD bivorced	Armed Forces?	1 ☐ Yes 2 🔯 No If Yes, Give		Hispanic Origin? (Saban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	y Yes or No- lan, etc.) 14. Race - American II Black, White, etc. Specify: Whi		
5-0 72 h 72 h natus	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occ	upation	dina	16b. Kind of Busin	ess/Industry	
1 21215-0 ed within 72 ho ygiene. For than "natur. It, the Wed cell	Elementary/Secondary (0-12)	College (1-4or 5	College (1-4or 5+)		e during most of wo				
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be fill doth	17. Father's Name (First, Middle, Li					18. Mother's Name (First, Middle, A			
ylan ouid be ouid be Mental arked o	John Edgar Gwi				Elizab	eth Hughe	S		
Nore, Maryland ; ges 1 end 2 should be filed t of Health end Mental Hyg if fram 27 is marked other or other traumatic event, To Be C	19a. fnformant's Name/Relationshi Edgar Gwin - I		1	-	et a <i>nd Numbe</i> r or R 106 Min				
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Baltin bepertmen important: any Injury	21. Signature of Funeral Service Li	cansee	nsee 22. Name and Addre			Capitol F	Funeral Service, Inc.		
_ 40264	Meren	· 11000	VOOL		721	l Lee Hwy	Falls	Church, VA	
death certificate be executed the electronic physicien end be for use as the burial-transit siciar/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Ora / Gu Due to (or as a conse	equence of):			<i>2</i> -15		
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	Part If. Other significant condition	contributing to death bu	t not resulting in the				Did tobacco use contribute to the cause of death? 1 ☐ Yes ⊅ No 3 ☐ Probably 4 ☐ Unknow		
COT requirements						24a. Was ar perform		4b. Were autopsy findings available prior to completion of cause of death?	
The law ate has pege 2						y⊠_Ye	s 2 No		
Vital I	25. Was case referred to medical				00 Bloom 10			1 DeYes 2□ No	
	examiner?	Hospital:			thor:	ath (Check only one			
Physic rithis or ral direction of T.	15 Yes 2 No 27, Manner of Death	28a. Date of Injury	t 2 ER/Outpati	BILL OL DOX	4 C Notishing I	lome 5 Reside		Specify)	
On On On On On On On On On On On On On O	1 □Natural 5 □ Pending	(Month, Day	Year) Folinjury	el w	ork? ☐ Yes 2 Z No	28d. Describe how injury occurred		unshot wound	
Division o To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Injur	5-8-00 1640 6				281. Location (Street and Number City or Town, State) 2202 Brooklandville, P		
To the Hospital Within 24 hours of To the Funeral I completely filled Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of aminer: On the basis of and manner state	my knowledge, dea	ith occurred at the	time, date and place opinion, death occu	and due to the ca	use(s) and manne	er as stated.	
Me of the	29b. Signature and title of certifier	3.00		29c. Licer	nse number	29	29d. Date signed (Month, Day, Year)		
	> Denni	of Chu	te no	oc	ME		MAY 09, 2000		
	30. Name and address of person with Dennis J.	1 1 -							
		hate mi)		Penn Str	eet, Balt	imore, Ma	aryland 2	21201	
State Registrar	MAY 1 8 2000	Server Server	- /	books	:				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Nama (First Middle Lest) 2. Data of Death 3. Time of Death Month **Physician** Robert Emory Miles 6, 2000 709 PM May 6, 4b. City, Town, or Location of Death /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 11328 Commanche Road Lusby Calvert 8. Data of Birth (Month, Day, Year) If Under 1 Year | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Days Hours Yrs. Director 15 6255 220 Aug 19 1984 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edicsi Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11328 Commanche Road 20657 United States Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental thyslene. Important: If Item 27 is marked other than "natural" or then any injury or other traumatic evant, the Medical Exertinations. 1 Yas 2 No If Yas, Giva X Year or Dates: M Nevar Married 2□ Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0020 Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a never worked 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Thomas W. Miles Katharine Ann Adams 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 11328 Commanche Rd. Lusby MD 20657 Thomas W. Miles- father 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata X□ Burial 2 □ Cramation 3 □ Ramovai from Stata May 9, 2000 \$t. Jon Vianney Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Prince Frederick, Maryland 22. Nama and Addrass of Facility 21. Signature of Furreyal Sarvice Licenses Rausch Funeral. Home PA 4405 Broomes Is. Rd. Part Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** fmmediata Causa (Final diseasa or condition rasulting in death) /Medical Examiner Dua to (or as a consequence of) Examiner PILEPTICUS sician and burial-transit The law requires that the deeth certificate be axecuted Sequentially fist conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last Dua to (or as a consequence of) Box 68760. attending physician for use as the burie ENNOX - CHITANT Physician/Medicai Due to (or as a consequence of) P.O. F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 2 No 1 Yes 3 Probably 4 Unknown Division of Vital Records. à 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yas 2 ☐ No Attending Physician: 25. Was case rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) 1 Yas Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury al Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural after death. Director: Af 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by à 4 ☐ Homicide 29a. Certifier Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and piace, and dua to tha cause(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of pertifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 5-08-2000 0050458 who complated causa of death (Item 23a) (Type, Print) Lexington Park, MD EMANN

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State

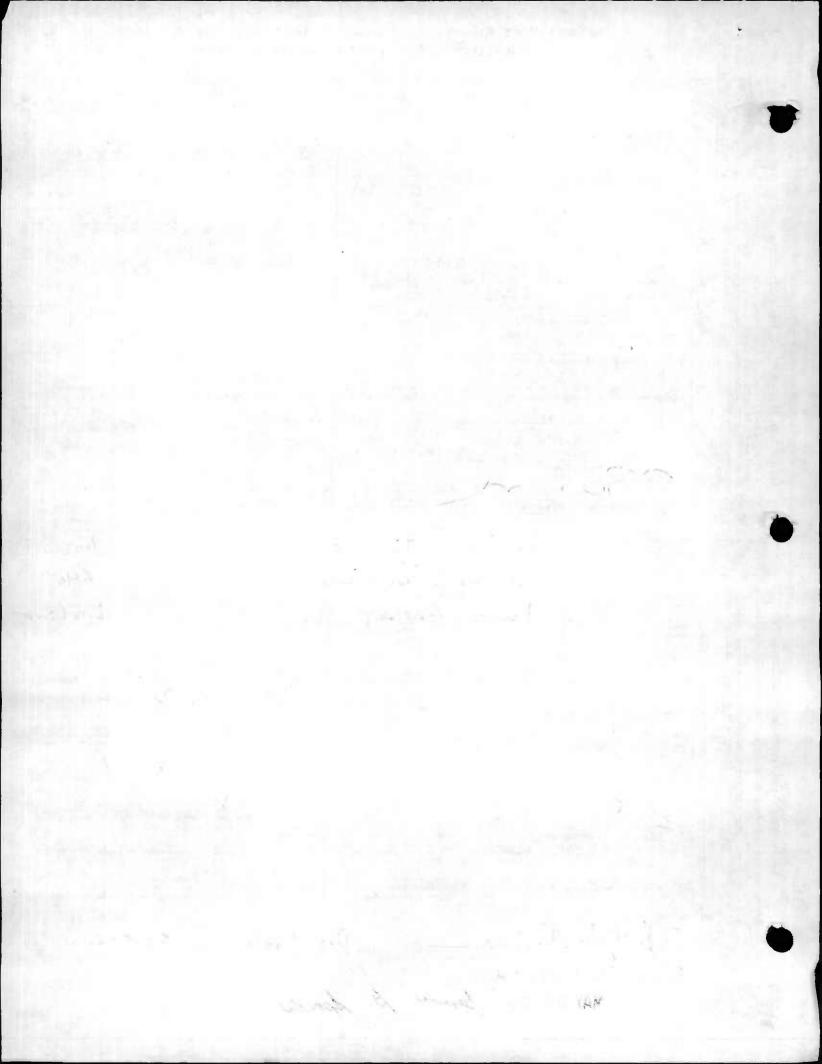
Registrar

31. Data filed (Month, Day, Year)

08

2000

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Robert George Moore 12:06 AM 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's Co. If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth Sept. 22,1942 Washington DC 6 Sex 7. Age (In yrs. last birthday) Days Hours 1√2 M 2□ F 57 213-42-7063 Yrs. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 25 No Maryland Prince George's Co Upper Marlboro 10e, Street and Number 10g. Citizen of What Country? 4411 Moores Way 20772 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Estimator Analyst Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George E. Moore Ada Chaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Betty Jean Moore (Wife) 4411 Moores Way Upper Marlboro, Maryland 20772 20b. Place of Disposition (Neme of cametery, crematory or other place) May 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 6,2000 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial Gardens Dunkirk, Maryland 22. Name and Address of Facility Lee Funeral Home, Calvert P.A. 21. Signature of Funeral Service License 8125 Southern Maryland Boulevard Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents Dua to (or as a consequence of) resulting In death) Last 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Be

Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show sub injury or other traumatic event, the Medical Examiner must be incitied at page.

Baltimore, Maryland 21215-0020

Examiner

buriel-transit and Physician/Medical detached þ Completed Be 2 Certification:

the attending physician hed for use as the burie 99 signed b peen The lew certificata has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Division of Vital Records. P.O. Box 68760 20

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ↑ Propatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₹ 27. Manner of Deeth 1 Deliatural 2 Decident 28c. fnjury et Work? 28e. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician 29a. Certifier Medical To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. in the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and minner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D52865

30. Name and address of person who d cause of death (Item 23a) (Type, Print)

7202 Quesenberry Way Bowie. MD 20720 .D. Figaro Kelson M.

31. Date filed (Month, Day, Year) 32. Registray's Signature

